DEPARTMENT OF STATE

Washington, D.C. 20520

U-1
8 Dec 76

NSC UNDER SECRETARIES COMMITTEE

CONFIDENTIAL
NSC-U/DM-130A

July 30, 1976

TO:
The Deputy Secretary of Defense
The Assistant to the President for National Security Affairs
The Director of Central Intelligence
The Chairman of the Joint Chiefs of Staff
The Deputy Secretary of the Treasury
The Under Secretary of Agriculture
The Under Secretary of Commerce
The Under Secretary of Health, Education and Welfare
The Director, Office of Management and Budget
The Chairman, Council of Economic Advisers
The Chairman, Council on Environmental Quality
The Director, National Science Foundation
The Administrator, Agency for International Development
The Acting Executive Director, Council for International Economic Policy

SUBJECT: First Annual Report on US International Population Policy

The Chairman has forwarded the attached Memorandum to the President. A copy is provided for your information.

Rutherford M. Poats
Acting Staff Director

Attachment:

As stated

U-1

CONFIDENTIAL

7616324

THE DEPUTY SECRETARY OF STATE

WASHINGTON

NSC UNDER SECRETARIES COMMITTEE

CONFIDENTIAL
NSC-U/DM-130A

July 29, 1976

MEMORANDUM FOR THE PRESIDENT

Subject: First Annual Report on U.S. International Population Policy

Responsive to NSDM-314, I submit herewith the first annual report on International Population Policy, which has been prepared by the Interagency Task Force on Population Policy. The report was approved by all Members of the Under Secretaries Committee; Treasury submitted a statement of clarification, which is attached to the report.

This report develops further the general strategy set forth in NSSM-200 study (approved by NSDM-314). It underscores in particular the NSSM-200 recommendation that the President and the Secretary of State, as well as our Ambassadors and others, treat the subject of population growth as a matter of paramount importance and address it specifically in their regular contacts with leaders of other governments, particularly less developed countries (LDC's).

In order to maximize U.S. popular and Congressional understanding and support for our international population programs, we recommend that at a suitable time there be at least a brief public Presidential statement of our international population policy and objectives.

In the last analysis, the problem must be resolved by the countries threatened by excessive population growth. Increasingly, these problems are being met through specific measures such as better

education and information programs, better outreach of family planning services and supplies, the development of more effective and acceptable means of contraception, changes in laws and policies to support family planning such as delayed marriage, and, most importantly, the improved status of women.

However, even in the aggregate, we believe that these approaches are inadequate to cope with the total problem. The report (Section II) therefore emphasizes three additional principal lines of attack that have already proved successful in several countries; and we should find ways to encourage their replication elsewhere: (a) strong direction from national and provincial leaders; (b) emphasis on community participation to root family planning in village life; and (c) integration of health, family planning, and nutrition, including training of competent multi-purpose paramedics to provide fellow villagers with family planning as well as other medical services. As for (c), Secretary Kissinger has already advocated this approach at the United Nations General Assembly Special Session last September and more recently at the Nairobi United Nations Conference on Trade and Development.

It should be emphasized that the funding levels set forth in Section VI of the attached report are illustrative only.

In the next few months as a matter of high priority, the Task Force will be directing special attention to how best to promote and strengthen effective population strategies in the key 13 countries cited in NSSM-200/NSDM-314, including our estimates of projected funding requirements. In addition, the Task Force will examine expected sources and adequacies of food, the relationship between these patterns and population growth, and implications for our population and other assistance programs. Over the longer term, the Task Force will be assisting AID's continuing efforts to develop and improve methods by which performance criteria for our programs in the key 13 and other countries can be utilized in the most effective and directed way.

Clearly, there is need for an expanded worldwide effort to cope with the problem. As pointed out in our assessment (Section I), excessive population growth is causing serious environmental deterioration, rising unemployment and underemployment, and a surge of humanity into cities where jobs, housing, sanitation, and other basic facilities are lacking. These overcrowded cities are spawning crime, social unrest, and potential extremism, all with serious strategic implications. Our own national security interests are ultimately affected. As nations increasingly feel the impact of excessive population growth, interest grows, and requests for assistance mount in this field. Any delays in implementing effective population programs will only make the ultimate problem far more serious and intractable. Under these circumstances, we believe there is clear justification for increased funding levels (generally as recommended in NSSM-200) which, together with anticipated increased contributions by recipient nations, other donors, and international organizations and private voluntary groups, will result in a more vigorous, effective attack on the problem.

It is specifically recommended that you:

(a) Approve the general strategy reflected in this paper, including a Presidential statement (proposed text is attached) at a suitable time, and

(b) Approve in principle an expansion of AID's population assistance program. The attached First Annual Report (specifically in Section VI) sets forth general program directions as well as illustrative funding levels.

Charles W. Robinson
Chairman

Attachments:

As stated

U.S. INTERNATIONAL POPULATION POLICY

FIRST ANNUAL REPORT

Prepared by the

INTERAGENCY TASK FORCE ON POPULATION POLICY
May 1976

INTRODUCTION

NSDM-314 of November 26, 1975, requires that the Chairman of the NSC Under Secretaries Committee submit annual reports, the first to be prepared within six months of the above date, on the implementation of U.S. international population policies as set forth in the Executive Summary of NSSM-200, modified by NSDM-314. The first required annual report is herewith submitted by the Interagency Task Force on Population Policy, established by the Under Secretaries Committee for the purpose of coordinating and implementing the above policy.

The first step taken by the Task Force in implementing the new Presidentially approved policies was to ensure that all responsible officials in Washington and the field were informed of the essential content of NSSM-200 and NSDM-314. It would be difficult to overstress the importance of involvement of our leaders, Ambassadors, and Country Teams in overseas population issues. In fact, this may be the most important conclusion of NSSM-200. Our officials must know about the facts of population growth and be fully persuaded of the importance of this issue. They must then find suitable occasion and discreet means to bring the message most persuasively to the attention of LDC leaders whose influence is decisive in shaping national policies and programs. Without this total involvement of our diplomacy, our efforts will fall far short of the mark.

To this end, and in order to increase U.S. popular support for involvement in international population programs, we recommend that there be at some suitable time at least a brief public Presidential statement of our international population policy and objectives.

This report is divided into six main sections, as follows:

I. The world population crisis: Its dimensions and responses by nations most affected.

II. Overall U.S. strategy and development of world commitment to population stabilization.

III. Maximizing efforts and contributions of other donors and organizations and improved coordination.

IV. Improved demographic information and data base.

V. Biomedical and social sciences research on broader factors affecting birth rates.

VI. Future direction for our AID programs, with projected funding levels for population assistance.

Special attention is called to the interrelationship between Sections I, II, and VI. Section I is a worldwide review of the population crisis based on information recently received from 77 U.S. Embassies in response to a Task Force circular instruction. This Section highlights fully as much as NSSM-200 the serious consequences -- environmental, economic, social, political, and even strategic -- of current population growth in many areas of the world, and yet Embassy responses also serve to underline the rising awareness amongst the LDC's, especially in Asia, of the need for effective counter-measures.

Section II underscores the need for our dealing with this worldwide problem as an integral part of our total diplomacy, specifically recommending how best we can direct our influence and support with regard to countries with varying degrees of commitment toward coping with their population problem.

Section VI, the major review of AID's population program directed in NSDM-314, recommends how, within that broad framework, our foreign assistance programs can be most effective, with particular emphasis on future directions and funding levels of population assistance.

I. The World Population Crisis: Its Dimensions and Responses by Nations Most Affected*

A. Embassy evaluations of the world population crisis largely substantiate the conclusions of NSSM-200, but with even greater emphasis on the significant impact of population growth on environment and on generating unemployment. Embassy evaluations are somewhat less concerned than NSSM-200 with regard to the availability of food to meet population growth in the immediate future. However, our Ambassadors see this as a serious threat in the longer run, with the LDC's increasingly dependent upon food imports, running deeper and deeper into debt and unable to finance the considerable capital cost involved in adequately expanding food production.**

B. A majority of our Embassies in Africa, Asia, and some in Latin America report large pockets of declining agricultural productivity due to widespread slash-and-burn farming, overgrazing, overcropping, often necessitated by population pressures. The cutting of forests for firewood and to clear ground for cultivation is particularly serious where it undermines soil stability and reduces protection against erosion. The examples of Nepal and Java are most striking in this regard, as is the northward and southward advancement of the Sahara.

C. Embassy responses also emphasize the serious implications of rising unemployment/underemployment, with countless millions unable to eke out a living in rural areas, jamming into already overcrowded cities where living conditions

---

*This section of the report is responsive to NSDM-314's request that we take a new hard look at the world population problem. All conclusions in this section are based on a lengthy analysis (summarized at Annex I) of responses the Task Force has just received from 77 U.S. Embassies in less developed countries. In other words, this section objectively reviews the problem as seen through the eyes of our Ambassadors and Country Teams.

**This conclusion is generally confirmed by a recent USDA report which concludes that, unless there is some check on population growth rates, "there ultimately is no solution to the world food problem."

for many are appalling. Such conditions can only spawn social unrest with serious political and even potential strategic implications. Embassy responses also underline the fact that migration abroad is no longer the safety valve is once was for relieving population pressures. European countries, in particular, are now more restrictive with regard to accepting migrant workers.

D. We were particularly struck by the trouble shaping up in our own Latin American backyard, basically due to some of the highest population growth rates in the world. Embassy Mexico points out that the number of "subsistence-level Mexicans may pose a severe internal security threat;" and that large numbers of illegal immigrants "could cause overwhelming political, economic, and social problems in the United States ..." and that it would be "an understatement to note that our bilateral relations will experience a great strain." A similar danger is brewing in Hispaniola. Embassy Santo Domingo reports serious concern over potential illegal immigration from Haiti and -- should domestic conditions deteriorate -- of the possibility of a Cuban-Haitian intervention in the Dominican Republic. Embassy Port-au-Prince agrees that attempts to emigrate illegally to the Dominican Republic "would lead to stern Dominican counter-measures and the resumption of open hostilities."

E. Despite these ominous conclusions, Embassy responses nevertheless point up the fact that more and more countries, including most of the big population countries, have taken counter-measures in the form of national policies and programs to control population growth, though the strength of their commitment and the efficiency of their programs vary widely. We conclude from Embassy responses that, of the 1.8 billion people living in surveyed LDC's (1) 1.3 billion live in 26 countries whose governments now have explicit population control programs related to their national economic development plans*; (2) 462 million live in 36 countries whose governments accept family planning as a means of improving maternal/child health but do not have government programs to limit population growth; and (3) 91 million live in 15 countries (mostly in Africa) where there are no population programs, and some of the governments are pro-natalist.

---

*With the inclusion of China and North Vietnam, 2.1 billion people live in 28 LDC countries with explicit anti-natalist policies.

F. Some 15 of the LDC's, according to Embassy reports, have already significantly reduced their birth rates. They include: China, Thailand, Republic of Korea, Colombia, Taiwan, Sri Lanka, Malaysia, Tunisia, Singapore, Jamaica, Costa Rica, Panama, Trinidad and Tobago, Mauritius, and Barbados. Additionally, Indonesia and the Philippines and at least parts of India (e.g., Kerala) have hopeful outlooks in fertility reduction.

G. On the other hand, our Embassies note persistent obstacles to acceptance of birth control in the LDC's including all the factors mentioned in NSSM-200 but also underscoring the fact that program implementation is badly handicapped in a number of countries through lack of executive talent (e.g., Egypt, Kenya, Ghana, Haiti, Iran, Malyasia, Nicaragua, Mali, Botswana, Nepal, Ecuador, Liberia) and shortages of professional manpower. Political sensitivities -- re birth control issues -- also impede vigorous implementation of governments' declared family planning policy in some countries such as Turkey, Morocco and Malaysia.

H. The overall conclusion to be drawn from Embassy reports is that current LDC population growth poses serious problems, but this is counter-balanced to some extent by encouraging evidence of greater attention to population policies on the part of most of the LDC's, significantly including the three largest: China, India, and Indonesia.

II. Overall U.S. Strategy and Development of World Commitment to Population Stabilization

A. U.S. strategy in dealing with the world population problem proceeds from a recognition of the disastrous implications of current population growth rates (including threats to our national security), and yet a counter-balancing recognition that the problem can be significantly eased if the nations of the world take prompt and effective countermeasures. The main task is up to nations handicapped by excessive population growth, which includes almost all the developing world. But these nations need outside help, and it must be our principal task to see that, in cooperation with other donor nations and organizations, we render effective assistance, when requested and desirable.

B. Whatever promotes stability, economic development, better health, improved education, and so on, particularly

as such measures broaden opportunities for women, will also create a more favorable setting for reducing current excessive population growth rates which in turn should induce countries to become committed to population stabilization. We therefore draw attention not only to the specific recommendations relating to AID programs in Section VI below but also to the need for overall assistance to the developing world along lines of the proposals made by Secretary Kissinger before the Seventh United Nations General Assembly Special Session and his specific suggestions made more recently before the UNCTAD Conference at Nairobi.

C. In the case of countries that have an announced national policy on family planning and development (hereafter termed the "committed countries"), the U.S. should, in addition to its current AID programs, discreetly promote three approaches that are interrelated and have proved highly effective:

1. Encourage national leaders to speak out clearly and firmly in support of broad-based population programs, while maintaining discipline down the line to see that population policies are properly administered and implemented, particularly at the village level where most people live;

2. Encourage these countries to adopt innovative approaches (which have already proved successful in several countries), designed to root family planning in the villages, relating family planning to the economic interests of the community, and thus creating peer pressures for limiting the size of families;

3. Train paramedics, midwives, volunteers, and others to provide general health services, including family planning in villages where these people are known and trusted. This extended personalized family planning advice, to be most effective, must reach women before they become mothers (so first births can be postponed if women so wish) and at least from the moment they have their first child, when spacing of children should be strongly recommended. Sterilization should be offered when the desired family size has been reached.

D. We recommend that U.S. officials refrain from public comment on forced-paced measures such as those currently under active consideration in India. The Indian Government's

demand for accelerated action is understandable, but there are moral considerations as well as practical obstacles to involuntary sterilization programs (inadequacy of medical, legal, and administrative facilities), and they might have an unfavorable impact on existing voluntary programs. This is not to be confused with a variety of individual and community incentive schemes the Indian authorities have under consideration to promote voluntary sterilization and other forms of contraception.

E. In the case of LDC countries uncommitted to population programs, our efforts must be fine-tuned to their particular sensitivities and attitudes. In the main, we should avoid the language of "birth control" in favor of "family planning" or "responsible parenthood," with the emphasis being placed on child spacing in the interests of the health of child and mother and the well-being of the family and community. Introduction and extension of primary health services are, in fact, the principal ways of successfully introducing family planning into many of these countries. We should also find ways, such as through informal personal contacts and special graphic presentations, to show leaders how current growth rates detract from their countries' economic development prospects. This, together with economic and demographic training of promising LDC officials, is particularly important in view of widespread unawareness of the economic facts of life, including wishful thinking that economic development will automatically resolve the population problem. Other recommended steps in dealing with the non-committed countries are to be found in Annex II.

F. We should lend even stronger support to worldwide efforts for the improved status of women and for their active participation in community and national life. The advancing status of women in parts of Asia and Latin America has evidently been a major factor in promoting successful family planning and in reducing birth rates.

G. In order to increase U.S. population support for involvement in international population programs, it would be helpful at some suitable time and occasion to have at least a brief public Presidential statement of our international population policy and objectives, in the context of our desire to improve conditions of life for mankind for endless generations to come. In all our statements, we should accent the positive, though warning that effective solutions will require the concentrated, sustained efforts

of nations and international organizations as well as the cooperative involvement of millions of dedicated people. We should ensure that all countries have the benefit of learning about approaches that have proved successful and might have wider applicability.

H. We must nevertheless be selective and low-key in our approaches, lest population programs otherwise be seen as primarily serving U.S. interests rather than those of other countries. That is why it is so important that the LDC's take more of a lead on population issues at international conferences and at home. A great deal of our work must involve personal contacts with men and women of influence in the LDC's and in donor countries, as well as with our Congress, the media, U.S. organizations, and groups of concerned citizens. We must help ensure that international organizations like IBRD, WHO, UNDP, UNICEF, and UNFPA, as well as private voluntary organizations, play an active, positive role in support of population programs, although we do not believe that further Bucharest-type meetings on population issues would serve any useful purpose at this time. The focus should now be on effective implementation of the Bucharest Plan of Action.

I. Over the next year, the Task Force will devote special attention to the five major population countries (Brazil, Nigeria, Egypt, Turkey, and Ethiopia) where there is little or no action in the population field; as well as to the other eight countries of the "big 13" listed in NSSM-200 (India, Indonesia, Bangladesh, Pakistan, Philippines, Thailand, Mexico, Colombia) which have active population programs, but where in most cases performance can be improved.

III. Maximizing Efforts and Contributions of Other Donors and Organizations and Improved Coordination

A. At a time when there is growing LDC concern and interest in combatting excessive population growth, it is particularly important that as many financial resources as possible are brought to bear on the problem, including assistance from other donor states as well as international organizations. While U.S. population assistance declined in 1974 and 1975 due to reduced appropriations, the contributions of other donor countries rose from $40 million in 1973 to $80 million in 1975 (about 1/3 of which was directed through UNFPA and IPPF); and further increases are projected for 1976. However, such key countries as the Federal Republic

of Germany, Sweden, and Belgium may be leveling off their population assistance. Our ability to play the leadership role stipulated in NSDM-314 and our success in getting other donor nations to do more will necessarily relate to increasing our own population assistance funding.*

B. If the U.S. announces its intention to increase its funding, we will be in a better position to carry out a major effort to get other donors to increase their funding beginning later this year. In addition to the traditional donors, we should also encourage the newly rich, oil-producing states to make contributions to the UNFPA, using the recent Libyan ($1 million) and Algerian ($500,000) contributions as a basis. The most effective channels in this regard are likely to be UNFPA or representatives of countries which have particularly close ties with the oil-producing states.

C. There is also need for improved coordination efforts amongst donors, particularly since many donors are now re-examining their overall development assistance programs in the context of population growth and are also giving greater attention to programs which provide improved basic integrated health/family planning/nutrition services with maximum rural outreach. With regard to coordination within countries, experience indicates that it can best be achieved in the capital of the recipient country through a group consisting of representatives of that country and all donor countries and organizations concerned. Although such formal groups are occasionally unacceptable to the host country for political reasons, some degree of coordination, however informal, is advisable in order that priority needs are met with minimum overlap and delay.

D. For international coordination, we recommend a three-tiered mechanism. First, general coordination of the population activities of donor nations could take place in the OECD Development Assistance Committee (DAC), with associated international organizations participating. Second, questions of population program funding levels and the impact of general development programs on fertility could be discussed at other meetings such as the "Tidewater" Conferences which are attended by heads of donor aid agencies. Third, senior officials specifically concerned with population assistance could discuss program design, recipient country problems, and other technical questions at periodic meetings which focus on specific issues. Efforts are already beginning in this direction.

* OMB Member questions this statement on the grounds that, as the major and most experienced donor in the field, the United States could presumably continue to play a leading role even if total funding remained level.

E. The United Nations Fund for Population Activities (UNFPA) and the private International Planned Parenthood Federation (IPPF) represent the two most important channels for assistance provided through international organizations and private intermediaries. These intermediaries can operate, though sometimes with limited efficiency, in countries where AID's bilateral assistance programs are not now acceptable. In over half of the key 13 NSSM-200 countries, the total U.S. effort is limited to our indirect support for activities of these intermediaries.

F. International and regional awareness of the problem of population growth has essentially been achieved; the time for national action is upon us. In response to country requests, the UNFPA is shifting from regional to specific country programs for which 80% of its 1977 budget will be allocated, either directly or through other UN agencies. However, UNFPA has not concommittantly shifted its program content emphasis from "consciousness raising" to the delivery of effective family planning services/information and to efforts to use development policies and programs more generally to affect fertility. We recommend that we use our influence through our UN delegation and in donor and recipient nation capitals to seek such a shift. Moreover, we must continue to press UNFPA to improve the efficiency of its operations.

G. In the past, the UN Specialized Agencies (SA's), e.g., FAO, ILO, UNESCO, UNICEF, and WHO, have administered most of UNFPA's operational programs using UNFPA funds. The SA's have used only limited amounts of their own resources for population programs and even then only for general and academic purposes rather than country specific and practical ones. As a result, we support the current trend in UNFPA to administer more of its own projects and the related need for increased staff and monitoring capability. We recommend, however, that UNFPA maintain liaison with the SA's to ensure that SA projects support fertility reduction. In addition, we recommend that the U.S. delegations to the various SA's be instructed to support coordination with the UNFPA and to push for consideration of secondary fertility reduction effects in SA projects.

H. Assuming that (1) the trends toward UNFPA-administered country-specific programs continue; (2) program content begins to shift as indicated in paragraph F; and (3) UNFPA program efficiency generally improves, we plan to increase our UNFPA contribution in order to bridge the current UNFPA gap between contributions ($76 million) and promising assistance requests

($105 million). This increase would be additive to the proposed expansion of the U.S. bilateral efforts espoused in Section VI.

I. Unlike UNFPA, IPPF and other private population-oriented intermediaries do not require explicit country agreements to operate. As private organizations, they require only acquiescence. As a result, they operate in the eight NSSM-200 big population countries in which the U.S. does not have bilateral population programs, most importantly in those whose governmental commitment to family planning is limited or non-existent, i.e., Brazil, Ethiopia, Nigeria, and Turkey. Through local subsidiary organizations, intermediaries like IPPF can act as local family planning advocates using local community leaders, a role no foreign government or international organization can hope to play. Although contributions to private voluntary population-oriented organizations mean less direct control of programs, we recommend, for reasons enumerated above, that AID continue to extend financial support to these groups provided they can program funds roughly according to the directions we outline in Section VI below and provided they can demonstrate that funds will be used with reasonable efficiency.

J. The World Bank Group is the principal international financial institution providing population programs. However, the Bank's policy prevents it from financing consumables such as contraceptives and other family planning commodities. This restricts its ability to finance population projects with its available funds. At present a high-level outside consultant group is evaluating the Bank's population programs. This evaluation and our review of it should help provide a clearer picture of what improvements there might be in the Bank's role and activities in the population field.

K. In addition, given the important secondary effects on fertility that general development efforts can have, we recommend that the Bank analyze the population impact of all its new projects, especially those in the newly constituted project area of nutrition.

L. As UNFPA has more demands for its assistance than it can fund, and as the World Bank is willing to provide more population assistance if promising requests exist, we recommend that the Bank coordinate with UNFPA to determine if some of these outstanding requests for population assistance can be met.

IV. Improved Demographic Information and Data Base*

A. U.S. policy in this field should focus on (1) increasing the flow of accurate and timely demographic information and (2) improving the demographic data base in both quantity and quality by:

1. Improving LDC capabilities to participate in both shorter and longer-term detailed survey activities which will generate more immediate information about the effectiveness of health, family planning, and related development assistance programs; and

2. Improving the capabilities of LDC's to participate in longer-term population census activities.

B. Given severely limited AID resources, primary emphasis should be given to the first area because of the urgent need to produce data in connection with on-going and projected studies and to take advantage of the opportunity to include the collection of data as an integral part of such programs. It is clear, however, that U.S. support for the latter, particularly the 1980 census program, should continue through U.S. assistance to activities basic to censuses such as training, computer software packages, and technical advisory services.

C. In the months ahead, activities in this field will be considered in light of available resources, other demands on these resources, and opportunities to relate them to programs of other agencies active in this field, including the United Nations and other international agencies.

---

* This draws on a special report by the Bureau of the Census.

V. Biomedical and Social Sciences Research on Broader Factors Affecting Birth Rates

A. The review of current research programs of the various agencies suggests limited change in prospective future actions in the various research areas. However, there is need for better focus and coordination among the two principal Federal agencies concerned: AID, which has been the leader in international population research, particularly as applied to developing countries; and the Center for Population Research in the National Institutes of Health, which has the world's largest research effort in population.

B. In coordination with NIH, AID should moderately expand its biomedical research effort, especially focusing on developing new and promising contraceptive methods (particularly reversible sterilization and injectibles) that will be appropriate to the needs of the LDC's, and exploring the adverse side effects of current contraceptive methods on various population groups among whom peculiar side reactions might be anticipated. NIH, in coordination with AID, should also pursue its biomedical research, which is oriented more to developed countries like the U.S. but frequently with potential worldwide application.

C. AID should expand its LDC-based research on comparative effectiveness of family planning systems with particular emphasis on low cost/village-based services using health auxiliaries and laymen, and it should continue to address the desirability and feasibility of integrating health, nutrition, and family planning services in a variety of ways in different circumstances.

D. AID should expand its social sciences research on the links between fertility and various aspects of development, particularly female education and employment, health conditions (especially of children), incentives/disincentives to encourage small families, income growth and distribution, and laws and policies which are supportive of family planning. Additional research is also needed on the implications of population growth for development.

E. The Center for Population Research in the National Institute of Child Health and various philanthropic agencies of the United States should also continue their work on the

development of contraceptive methods. Field-testing of new contraceptive methods in the LDC's should be only on request and with approval of the local government, and should have as its prime objective a benefit for the particular people upon whom it is being tested.

F. Finally, the Interagency Committee on Population Research should develop a plan for the improvement of coordination among the various U.S. public and private agencies to ensure maximum productivity from public outlays. Similarly, the U.S. should encourage closer coordination with the research programs of other international donors to provide maximum exchange of information and earlier exploitation of prospective breakthroughs.

VI. Future Direction for our AID Programs, with Projected Funding Levels for Population Assistance

A. This Section of the report relates how, within the broad framework of the preceding Sections, our foreign assistance programs can best achieve the most voluntary reduction in fertility with limited funds. We fully support the conclusions of NSSM-200 that far greater efforts, including more U.S. population assistance, will be required to cope adequately with world population growth. The need is compelling (see Section I); the interest and demand are rising (see Section II). Moreover, more attention must be given to the potential indirect impact on fertility of development programs and policies in general.

B. This broad-gauge approach could reduce fertility dramatically in the next decades, but the population problem cannot soon be erased. Because of the youthful age structure of the populations of today's developing countries, population growth will persist for some time to come, even if the two-child family should suddenly become the norm.

C. In response to NSSM-200 and NSDM-314, AID had undertaken a broad review of efforts (particularly U.S.-assisted efforts) to reduce fertility. Based on this analysis, AID has established program directions for population-related assistance over the next several years.

D. Consistent with the findings of NSSM-200 and NSDM-314, due priority is given to the 13 big population growth

countries (Brazil, Colombia, Mexico, Nigeria, Ethiopia, Egypt, Turkey, Bangladesh, India, Pakistan, Indonesia, Philippines, and Thailand). AID has given major assistance directly or indirectly to Colombia, India, Bangladesh, Pakistan, Indonesia, Philippines, and Thailand. But India, Brazil, and Mexico do not now desire U.S. bilateral assistance; Colombia has asked AID to phase out; Turkey has taken only limited steps; and Nigeria and Ethiopia have shown little or no interest in their population problems. Each of the 13 countries poses special problems; the courses appropriate to each country are not the same.

E. In the past several months, useful high-level meetings on population issues have been held with Asian leaders. As a result, our Embassies report both the Philippines and Pakistan are undertaking additional measures to make contraceptives more widely available to the villages. Other steps are under active consideration to promote family planning measures in Brazil, Colombia, and Egypt. In the countries not desiring bilateral U.S. population assistance, particular attention is paid to specific opportunities to assist through intermediaries (e.g., IPPF or UNFPA) that can operate efficient programs along the directions outlined below.

F. Moreover, AID seeks additional opportunities to assist in a limited number of other countries where prospects for demographic impact are bright or where experience applicable to major countries can be gained. Specific country program strategies will be developed and reviewed in the next year in the context of the overall program directions described below.

G. Designing programs to reduce fertility must take into consideration individual couples' choices about childbearing and family planning. Couples need not affirmatively decide to have a child. But they must affirmatively decide to practice family planning. Consciously or unconsciously, they weigh the pros and cons of another child against the pros and cons of available means of family planning. Their attitudes toward family planning depend on the type, cost, and accessibility of the services available to them and also on the extent to which they accurately understand those services. Their views on the desirability of a child are most complex, and depend largely on the social, cultural, and economic milieu.

H. Providing better family planning services and information is the most obvious way to tip parental decisions in favor of family planning. Better services and information can avert extra births that couples do not affirmatively seek. They can also help reduce insurance births as wider spacing of pregnancies helps to improve the health of existing children. Less obviously, they can indirectly influence the number of children parents seek; for as services change family size, they help modify future family-size norms.

I. Thus, most population programs have concentrated on developing and extending better family planning services and information. Over the past decade, AID has devoted some $750 million to population assistance, primarily to improve and extend services and information. While it is difficult to quantify the demographic impact precisely, available evidence indicates that AID assistance has been quite significant, particularly in Asia. Since services are as yet really accessible to only about 15% of most LDC populations, expansion of AID population assistance of this sort should bring about further birth-rate reductions. A principal focus of the program directions is on determining more accurately what assistance measures work best. While the Annex (and other studies available to those interested) summarize available evidence, there is as yet no litmus test to guide us in predicting the most successful program mix in each country setting. Similarly, there are as yet no universally applicable performance criteria, but benchmarks are established for assessing program performance that reflect individual country conditions.

J. But family planning services and information alone will not likely bring birth rates down to current LDC target levels, much less to stable population levels which would require an average family of only slightly more than two children. As emphasized at the World Population Conference and elsewhere, many parents apparently want three or more children even when safe, effective, acceptable, and affordable family planning services are readily available. Thus, development policies and programs can be specifically tailored to change the social, cultural, and economic milieu to encourage smaller families, thereby effectively complementing better family planning services and information. The policy options vary widely, but improving the status of women and increasing their basic opportunities is apparently of fundamental importance in lowering fertility. Finally, and most importantly, the types of

measures specified in Section II above with regard to leadership direction, community approaches, etc., should help influence decisions for smaller family sizes.

K. Program Directions: Consistent with the broad policy emphasis described above, this section sets forth AID's program directions in two parts -- (1) Population Assistance and (2) Other AID and P.L. 480 Assistance.

(1) AID Population Assistance

L. As in the past, AID population assistance funds will be used primarily for family-planning service delivery; education and publicity programs; training of family planning personnel; directly relevant research; provision of population-related components in broader education, health, nutrition, rural development, and other programs; and exploration of the links between development and fertility. The new emphasis will be reflected in the program mix as indicated below.

M. A major AID thrust in family-planning service delivery, as in the broader health area, will be the development of less expensive and more widely dispersed systems of service delivery capable of reaching the large masses of the poor, and particularly of the rural poor. The expensive and usually urban clinics with which family planning programs have typically started cannot reach the rural poor. Thus, AID is vigorously encouraging development and extension of basic, low-cost, village-based services. This will involve both greater use of paramedical and volunteer staff and integration of health, nutrition, and family planning efforts at the lowest sensible level.

N. AID's program directions are arrayed in six functional categories of assistance and are as follows:

Category 1: Demographic Data

-- Place less emphasis on relatively less detailed censuses (see Section IV above).

-- Moderately expand efforts to develop more detailed demographic data to permit better program-impact analysis.

Category 2: Population Policy

-- Moderately expand research, particularly LDC-based, on linkages between fertility and various aspects of development, particularly including:

a) female education of various types and levels;
b) female employment;
c) health (especially of children);
d) nutritional status of women and children;
e) incentives/disincentives to encourage smaller families;
f) income growth, distribution, and rural development (especially as to food);
g) laws and policy statements supporting family planning.

-- Moderately expand measures to bring out the development implications of population growth and the potential for influencing fertility through development programs.

-- Moderately expand pilot projects and experiments in areas a)-f) above, providing technical assistance or financial support.

Category 3: Research

a) Bio-medical Research*

-- Moderately expand projects to field-test internationally promising new family planning methods.

-- Moderately expand research to develop or improve new methods (especially once-monthly methods and reversible sterilization) and international research on side effects of available methods, especially pills, among particular users.

-- Moderately expand research on the relationship between nutritional status and fertility.

---

*Subject to legislative restrictions, e.g., the Helms Amendment which prohibits support for abortion-related assistance other than research.

b) Operations Research

-- Sharply expand LDC-based research on the comparative effectiveness of alternative approaches to family planning services and information, focusing particularly on low-cost, village-based distribution using health auxiliaries, etc.

-- Sharply expand research on the extent to which such village-distribution schemes require clinic backup.

-- Moderately expand research on prospects for LDC production of contraceptives and other family planning supplies.

Category 4: Family Planning Services

-- Encourage provision of a variety of family planning methods, particularly pills, condoms, and sterilization.*

-- Sharply increase efforts to help establish and expand village-based distribution of family planning services in rural areas particularly through low cost systems relying on health auxiliaries and laymen, working through local leadership, and promising short start-up time.

-- Encourage integration of health, nutrition, and family planning services wherever sensible, taking care to encourage movement on either the health or family planning front where simultaneous movement may be very difficult.

-- Seize opportunities to "piggyback" family planning services on existing delivery systems, particularly clinics, where they are available (e.g., some Latin countries).

-- Encourage allocation of health funds to establish broad-based, low-cost delivery systems that could add in family planning where that approach seems most promising (e.g., some African countries).

---

*Subject to legislative restrictions, e.g., the Helms Amendment which prohibits support for abortion-related assistance other than research.

-- Encourage provision of appropriate contraceptives through private channels (e.g., midwives) or commercial outlets.

-- Work with intermediaries, public-funded programs, or both, depending on potential effectiveness.

Category 5: Information, Education, and Communication (IEC)

-- Undertake broad family-planning awareness campaigns largely only where general awareness is very limited.

-- Where basic awareness exists, fine-tune existing IEC efforts so they are:

a) country and culture specific;
b) informative on each specific method of family planning;
c) related to personal needs and aspirations;
d) focused considerably on the interface between village family planning worker and village client;
e) reliant on relatively inexpensive media with broad outreach that require little or no reading (e.g., radio).

-- Sharply expand operational field testing to better determine which combinations of the many modern and traditional media are most effective and appropriate.

Category 6: Manpower and Institutional Development

-- Sharply expand efforts to assist LDC-based training of health auxiliaries or laymen for village-based distribution.

-- In countries having enough basic family planning workers at present, focus on filling specific institutional and personnel needs.

-- Moderately expand efforts to strengthen planning and management capacity at all program levels.

O. Funding Levels: To carry out this program, AID estimates population funding levels of over $200 million (including UNFPA) will be needed annually over the next several years with a possibility for increased levels beyond this, given the enduring quality of the population problem. Obviously, the exact budget level in any given year will

need to reflect LDC interest and absorptive capacity, the effectiveness of on-going programs, other donor activities, research breakthroughs, and competing demands on funds. In Table 1 at the end of this Section, rough suggestions for total future population funding indicate the scope of the population problem and the shape an expanding program might take, consistent with the policies described above. These estimates could -- and should -- change based on specific country program strategies that will be drawn up as a result of this NSDM review.

(2) Other AID and P.L. 480 Programs Relating to Fertility

P. In the FY 1978-79 Foreign Assistance Act legislation recently forwarded to the Congress, the importance of non-population programs as an influence on fertility is recognized. AID will increasingly give this factor weight in developing and implementing its programs, as the following illustrations suggest:

1. Rural development.

-- Plan, administer, and evaluate coordinated packages of policies and programs (including P.L. 480 Title II, Food-for-Work) designed to foster production, promote employment, lessen urban migration, expand opportunities particularly for women, promote more equitable distribution of goods and services, and encourage smaller families.

2. Health.

-- Reducing fertility is a primary objective since it contributes directly to better health of mothers and children.

-- Appropriate integration of health, nutrition, and family planning measures is receiving higher priority.

3. Nutrition.

-- The relationship with fertility is also very close; for example, breastfeeding helps both to improve child nutrition and to postpone pregnancy.

4. Education.

-- Much greater attention should go to seeing that programs of all sorts reach more girls and women, who are usually a distinct minority among the beneficiaries.

While imperfections of both statistical data and methodologies preclude precise estimates of the impact of these approaches, more will be done to clarify the picture in the future. Thus, the Agency will be better able to assure that all measures having a major influence on fertility -- or on health, or on well-being however measured -- can be coordinated more effectively to assure maximum impact. An independent analysis of population-related assistance (Annex III) has been prepared by AID to provide more detailed information.

TABLE 1
- 23 -

U.S. Population Program Assistance

Estimate of Future Requirements

($ millions)

Functional Area	FY 1975 Actual	FY 1976 CP*	IQ CP	FY 1977 CP*	FY 1978 Est.	FY 1979 Est.
1. Demographic Data	11.9	11.6	5.6	11.3	16	20
2. Population Policies	4.8	7.2	1.6	8.6	16	20
3. Fertility Control	5.6	8.5	2.4	13.0	22	30
4. Family Planning Services	53.0	71.8	16.1	84.4	115	143
5. Information Programs	13.0	17.1	4.2	16.2	20	27
6. Manpower & Institutions	11.7	17.2	6.5	20.6	26	30
TOTAL	100.0	133.4	36.5	154.1	215	270
(of which UNFPA)	(20)	(21)	(4.6)	(25)	(42)	(46)

*CP (Congressional Presentation) indicates the population assistance program to Congress with AID's request for appropriations. For FY 1976 there is a Conference Report appropriating at least $103 million for population assistance.

Approved For Release 2003/08/08 : CIA-RDP79M00467A002500120004-8

ANNEX I

The World Population Problem: Its Dimensions and Responses by Nations Most Affected

(Summary of Embassy Evaluations)

1. Economic Implications of Population Growth

A. The majority of Embassies perceive serious economic consequences of population trends in host countries. Inability to feed the growing numbers is a major concern. Inadequate domestic production, it is pointed out, necessitates food subsidies and imports which, in turn, impose a priority claim on the nation's limited budgetary resources and foreign exchange.

-- In the absence of more stringent birth control measures, Embassy Manila expects severe strains on the Philippines' food supply. Presently, large segments of the population are suffering caloric and protein deficiencies. This situation can be expected to continue and worsen until a significant decline in population growth is achieved.

-- Burma's population is eating up the nation's exportable rice surplus. This will soon eliminate the country's most important source of foreign exchange and put an additional strain on Burma's already precarious balance of payments.

-- In order to achieve domestic self-sufficiency in food-grains and to raise average consumption to minimum caloric requirements by 1985-86, Bangladesh would have to increase its annual rate of growth of food production from the present 1.6 percent to 3.3 percent. This would have to be accomplished almost entirely through improved productivity, including multiple cropping. Despite the theoretical possibility of achieving this goal, Embassy Dacca considers it "most likely" that Bangladesh will continue to require substantial food imports.

-- Before 1960, Morocco was capable of exporting its surplus cereals. Since the late 1960's, cereal production has not kept pace with

population growth. Cereal imports absorb much of the increasing foreign exchange revenues generated by the sale of phosphates. Morocco registers a 40 percent incidence of degree malnutrition (i.e., between 20 to 40 percent underweight) among children 0-4 years of age.

B. The probability of rising unemployment and/or underemployment is emphasized by a majority of reporting posts. The bases for their conclusions are the inevitable acceleration in the growth of the population in working ages, resource constraints for job-producing investments, and in some countries, policies favoring more profitable, technically advanced, capital-intensive projects.

-- The Philippines have failed to provide adequate productive employment for the past 30 years, due to their rapid population growth. Currently, "with 800,000 new entrants and 300,000 retirees, the economy must produce 500,000 new jobs annually, at a time when the agricultural frontier of Mindinao is closing and when the recently expanding service sector appears bloated." It is "highly problematic" whether the employment picture will improve significantly in the future, as by 1980, there will be over one million new entrants into working ages.

C. Embassy responses also touch upon the broader ramifications of the unemployment problem, including the question of popular participation in the generation and distribution of national income. Lack of productive job opportunities is seen as helping to perpetuate politically destabilizing economic inequities within LDC's.

-- Present prospects in Honduras are for income distribution to become more inequitable. Unemployment, already high, will increase, exerting downward pressure on wage levels and reducing the possibility for accumulation of savings.

-- "Although Mexico's economic growth has been outstanding, the position of the lowest income group has probably not improved over the past 20 years, nor is it likely to do so in the next 20."

-- Indonesia's development program appears to have become more rather than less capital-intensive. "If this is true and continues...[it] would lead to a substantial worsening of the distribution of income in Indonesia and quite possibly to an increase in the number of people unable to meet their minimum economic and social needs."

-- Although Kenya had achieved a commendable growth record, development planning was not addressing the question of distribution of benefits of growth.

-- In Pakistan, the potential for economic development is high. However, "if the dependency ratio remains high, if population pressure does create increasing unemployment, Pakistan will find its scarce resources being siphoned off into subsidies and welfare programs..."

D. In addition to population imbalances in respect to food and work, Embassies emphasize that the need for health care, education, housing, and other vital services created both by increasing numbers and the youthfulness of the age structure, puts a severe strain on limited public and private investment resources. Pakistan, for example, has steadily been losing ground to population growth, despite the government's efforts to increase the provision of such services. While between 1950 and 1975 the number of school-age children in primary schools increased from 0.9 to 4.7 million, the absolute number out of school increased from 4.5 to 5.3 million. An illustration of the growth of awareness of the population's impact on the need for public services is given by Embassy Lagos:

-- "The leadership has recently, and for the first time perhaps, been brought face to face with the reality of what a high growth rate can mean for the provision of adequate facilities for a rapidly growing population even when necessary resources to do so are available. In launching the Universal Primary Education (UPE) scheme scheduled to begin in next September, the

> authorities have been confronted with a host of problems in planning and providing the necessary infrastructure and facilities for the huge and growing primary school population. For the first time, officials in Nigeria are dealing with the realities of a high growth rate rather than the theory. It is felt that the experience with UPE and other planned programs designed to provide coverage to the total population or large segments thereof, will go a long way toward generating more concern for population dynamics and their implications than currently exists in Nigeria."

E. A number of Embassies view the rapid growth of major cities in host countries as one of the most serious population problems. Heavy rural-urban migration adds to pressures for public services which in rural areas could be more easily ignored. Embassy Manila also notes that urban migrants depress wages in the industrial sector, "profliferate low [labor] productivity," and make squatter settlements a "perennial problem." Embassy Ankara reports that about 40 percent of Istanbul-Ankara and 35 percent of the Izmir area "are made up of squatter settlements of minimal housing standards." Sanitary conditions and other vital services are inadequate and outbreaks of cholera have been reported.

F. In a more comprehensive view of Ghana's development problems, Embassy Accra observes:

> -- "It would be a mistake to attribute the economic and financial difficulties faced by Ghana solely to population trends... Many other elements of the politico-economic equation are more directly responsible for the virtual absence of per capita growth over the past sixteen years, the recurring balance of payments crises and structural disequilibrium, as well as the rising budget deficit. Public sector consumption (i.e., current expenditures) appear to have absorbed the major part of the increase in GDP in the period 1965-1975. This trend appears to be significantly (though not exclusively) related to demographic factors, including the high dependency ratio...and rapid [population] growth...

> "The high rate of increase in public consumption has been a major reason for the disappearance of public savings. The resource pinch restricts the availability of funds for public investment, with the result that the nation's infrastructure has deteriorated over the past 15 years. While economic difficulties and management decisions and indecisions have played a major part in determining these trends, demands deriving from the high population growth rate have also clearly had a key role."

G. Some eighteen Embassies perceive little impediment to the growth of national economies in consequence of demographic trends. Embassy N'Djamena argues, in fact, that the impact of population growth on socio-economic development cannot be considered only in negative terms. It should be viewed also as a factor "in the requirement for increased productivity and markets." A few Embassies report special conditions which may moderate the potentially negative impact of rapid population growth (Iran, Nigeria, Zambia, and Costa Rica). The Government of Zambia, for example, has been encouraging the urban unemployed voluntarily to return to the farms. Since this approach has not achieved the desired results, the Government--using Presidential powers under the state of emergency proclaimed in January 1976--may soon order compulsory transfers of "surplus urban population" to the countryside. In Costa Rica, the extremely high population increase of the 1950's and 1960's is now creating serious socio-economic dislocations. Family planning efforts, however, are already moderating the situation at particular points in the social infrastructure (e.g., occupancy of maternity wards, primary school enrollment).

2. Enviromental Implications of Population Growth

Most Embassies, particularly those in Latin America, take note of the manifest deterioration of urban localities. Sanitary facilities, to include potable water, sewer and waste disposal systems, are frequently unable to cope with the massive inflow of rural migrants. The most dramatic ecological problems appear to arise in rural areas, however. A majority of Embassies in Africa, Asia, and some in Latin America report large pockets of declining agricultural productivity. This is usually attributed to poor agricultural practices, including widespread slash-and-burn farming, cultivation of steep mountain slopes, overgrazing, overcropping, and the plowing up of drought-prone grassland. Indiscriminate cutting of forests for

firewood, or to clear land for cultivation, is particularly serious where it undermines soil stability and reduces protection against water and wind erosion. Population pressure severely compounds the problem and, in some countries, makes harmful agricultural practices necessary (e.g., Mexico).

Nepal is considered an example of "ecological disaster in the making," because of the pressure of population in the hills and uncontrolled settlement in the lowlands. It is estimated, for example, that food production on newly opened lands in the lowlands is more than offset by losses in production caused by erosion in the hills.

Java, in the judgment of the Embassy, may become a wasteland. Soil erosion due to overpopulation is already creating an ecological emergency. Overpopulation has led to deforestation (two-thirds of Java's forests have disappeared since 1940) and misuse of hillside areas by land-hungry farmers.

With respect to the recent Sahelian disaster, Embassy Dakar (Senegal) notes that "in the view of many observers," the pressure of increasing numbers of men and animals on the fragile Sahelian ecology removed vegetal cover and was instrumental in bringing on the drought of 1969-1973. Embassy Nouakchott (Mauritania), on the other hand, contends that, although the problem would have been less severe with fewer people to feed, the drought was caused by a lack of rain, with no significant contribution from overcropping, overgrazing, erosion, or overpopulation. The Embassy, nevertheless, urges that the AID Task Force include a prototype population program in its development strategy for the Sahel region.

3. Political Implications of Population Growth

Review of Embassy responses to this question suggests a distinction between internal and external threats to the stability of governments in consequence of population growth. The former derive from governments' inability to cope with the growing populations' demands for food, work, and vital public services. The latter derive from attempts to take advantage of the above situation, from repatriation of migrant workers, from tensions due to illegal border crossings in search of jobs, and finally, from underpopulation which may invite external encroachment and interference.

Internal political disruptions in consequence of socio-economic difficulties have arisen in, and still threaten, Indonesia, Colombia, Ghana, and other LDC's. There are countries like Turkey where high unemployment and huge squatter settlements exist, but Embassies believe that explicit policy to control the high birth rate would itself be politically destabilizing. Mexico's situation has international as well as internal political ramifications. The Embassy calls attention to high unemployment and poverty undiminished by economic growth. Even under the most favorable projections of population growth, the number of "subsistence-level Mexicans may pose a severe internal security threat." Moreover, large numbers of illegal immigrants "could cause overwhelming political, economic, and social problems in the United States... Since the very movement of such large numbers of people would be disruptive to both societies, it is an understatement to note that our bilateral relations will undergo great strain." The Embassy warns of the sensitivity of the Government of Mexico to this subject and that "we must be prepared for the possibility that Mexican birth control programs cannot be implemented more rapidly than at present..."

The Embassy in Santo Domingo reports serious concern over illegal immigration from overpopulated Haiti and--should Dominican conditions deteriorate--of the possibility of a Cuban-Haitian intervention in the Dominican Republic, which would entail a threat to the Panama Canal. Embassy Port-au-Prince agrees that attempts to emigrate illegally to the Dominican Republic "would lead to stern consequences and the resumption of hostilities." It also expects unrest in Haiti, growth of radical movements, and reversion to more repressive forms of rule.

In North Africa, the effect of a worsening of the population situation in pro-Western Tunisia is described: "Subversion from Algeria and Libya is a threat...that will increase dramatically if population growth leads to a reduced standard of living and unrest." Similarly, Morocco's strategic position in North Africa, its traditionally good relations with the U.S., and its role of moderation in the Arab world make it important, in the Embassy's view, that political and social stability be maintained. The Embassy also sees pressing population problems working against such stability.

In countries where export of labor has been a safety valve for local overpopulation, the return of this labor is a matter of some concern. Large-scale repatriation of the 3 to 5 million Nepalese residing abroad, for example, would create "intolerable economic and social burdens," with attendant political repercussions. In Lesotho, the need to absorb its labor force now residing in South Africa would create a "disastrous" situation. A similar problem obtains in the Middle East in consequence of migration to oil-rich countries. Embassy Sana reports that "should Saudi Arabia expel the Yemeni now working there, the pressure on savings, employment, and social services (in Yemen) would quickly become crippling and political disruption would follow on a domestic and visibly international basis."

A special difficulty appears to exist in Burma. Partly because of fears of illegal encroachment from China, India, and Bangladesh, Burma maintains a high birth rate. This, in turn (as mentioned above), threatens Burma's continued ability to export rice.

Some twenty Embassies, including Ankara and New Delhi, do not anticipate serious political or strategic consequences because of population pressure, now or in the near future. New Delhi's optimism is based on India's low population density.* Embassy Ankara, perceiving at present no evidence of demographically induced disorder, conjectures that "several years from now" concentration of the unemployed in Turkey's urban areas may, under certain circumstances, increase political problems.

Embassies in Argentina, Ivory Coast, Saudi Arabia, Libya, Gabon, and Guinea express their own or host governments' opinions that the small populations of the respective countries weaken their political influence or strategic posture, as well as impede development.

4. Family Planning Programs

By 1976, the majority of the LDC governments have accepted the concept of the public provision of family planning services. This group includes People's Republic of China, Cuba, and North Vietnam, not included in this review.

* Elsewhere in its response, the Embassy reports an "immense" unemployment problem--"(so far) unexplosive in nature"--and a steady growth in the number and proportion of landless laborers in India.

Of the 77 LDC's participating in the survey, 62 have some kind of organized program. Of the 62, eight countries only permit private organized activities in this field* (Tables 1 and 2). Thus, 54 LDC's can be said to have discernible governmental sponsorship or involvement in family planning programs. The nature, scope, and effectiveness of these programs vary widely, however. This reflects, in no small measure, the degree of governments' awareness of local demographic trends and their perception of the significance of high fertility levels for LDC priority concern: national development. The Indonesian Government, for example, has assigned very high priority to the family planning program in terms of political, institutional, and budgetary support. The Government of Brazil, on the other hand, having acknowledged its responsibility to provide family planning services for the poor, has done nothing to carry out this policy. Similarly, in resource-rich Nigeria, the Federal Government has announced a population policy, but made no concerted effort either to promote or to discourage responsible parenthood. "State governments show a growing interest (as does the Federal Government) in family planning integrated with MCH** services but give no evidence of pursuing even this approach with much vigor in the immediate future."

Ethiopia ranks lowest, perhaps, among the 13 priority LDC's in terms of government's commitment to family planning programs. The country's Provisional Military Government does not see a need for a reduction in the population growth rate. It stresses economic growth both as a solution to Ethiopia's underdevelopment and as the setting for fertility decline. Since the two-year old government is currently preoccupied with "efforts to define a political philosophy, to create a mass-based political structure, and to retain or establish political cohesion," the Embassy thinks it unlikely that the GOE will reconsider its population views before 1980. Nevertheless, the Government permits private efforts to add family planning services, contraceptives, and training to both Government and missionary-operated health clinics. The number of clinics which include a family planning component has grown from 29 in 1972 to 168 in 1976.

* Jordan, Syria, Senegal, and Madagascar, among the eight, have shown evidence of increasingly favorable governmental attitudes toward public provision of family planning services for non-demographic considerations.

** MCH - maternal and child health.

Among the 54 LDC's officially supporting family planning programs,

-- 26 LDC's, with a combined population of 1.3 billion, have established explicit policies and programs to reduce average fertility levels in the interest of economic and social development (Table 2). While this group represents about one-third of the countries in the survey, it contains 70 percent of the population.

    Singapore is reported to have reached replacement-level fertility in 1975. Ten other LDC's in this group, according to Embassy reports, have measurably reduced their birth rates. They include Thailand, Korea, Colombia, Taiwan, Sri Lanka, Tunisia, Jamaica, Trindad & Tobago, Mauritius, and Barbados. In addition, Embassy Jakarta is hopeful about the outlook for fertility reduction in Indonesia.*

-- 28 other LDC's, including Brazil, Turkey, Nigeria, and Ethiopia, support family planning as a means of improving maternal and child health, of raising general family welfare, and/or in recognition of the rights of the couple to determine the number and spacing of their children.

    Three of the 28 LDC's, according to Embassy reports, have significantly reduced their birth rates (Malaysia, Costa Rica, Panama).

Among the remaining 13 priority LDC's, Mexico's program is too recent to judge its effectiveness. Pending the completion of the 1976 census, Embassy Cairo does not have an accurate estimate of Egypt's population growth. The country's relatively low growth rate of 2.1 percent for 1973 may reflect a temporary decline in the birth rate due to mobilization for the 1967 and 1973 wars. Embassy New Delhi does not evaluate India's program in terms of its effect on the birth rate. Policy innovations since 1974 suggest that the program's overall performance fell short of expectations. More specifically, "lack of effective family planning programs particularly affects the rural problem." Embassy Islamabad believes that "it is not yet possible to be very sanguine about fertility decline in Pakistan." The program has not been "dramatically effective," at least not prior to the inception in early 1975 of the "contraceptive innundation" program, whose

* Results of the 1975 Philippine Census suggest some fertility decline in the period 1970-75. Embassy has not analyzed the data and cannot now assess their accuracy.

Embassies report declining birth rates in following host countries:

		Birth Rates (per 1,000 population)
Trinidad & Tobago	1950	37.5
	1973	24.7
Panama	1960	39.9
	1970	37.1
	1974	31.2
Costa Rica	1960	47.5
	1973	28.3
Mauritius	1965	41
	1974	13*
Taiwan	1963	34.5
	1975	23.4
Korea, Rep. of	1961	42
	1975	24
Tunisia	Over past decade	47
		36
Colombia	Late 1960's	44
	Current	36-48**
Thailand	1972	3.1 percent growth rate
	1974	2.56 percent growth rate
Sri Lanka		"Declining growth rate"
Malaysia		"Population growth rate declining"
Barbados		"An effective program"
Jamaica		"National acceptance of family planning has been excellent"
Singapore	1975	"Replacement-level fertility"

---

* UN's Monthly Bulletin of Statistics for April 1976 reports the birth rate of 27.1 for Mauritius in 1974. It declined to 25.1 in 1975. The figure in the Embassy's cable is believed to be a typographical error.

** Preliminary analysis of Colombia's 1973 census results indicates a possibility of an even steeper decline in the country's birth rate.

aim is to assure "a virtual doorstep availability of contraceptives."* In Bangladesh, execution of the program initiated in 1973, "has not squared with the note of urgency surrounding its adoption," although in 1976, the prospects for vigorous implementation appear to have improved. As in Pakistan, the "core" of the current strategy is doorstep delivery of MCH and family planning services.

In the Philippines, "overall program performance...is a mixed picture. In the [short] span of five years, the country has moved from a pro-natalist policy of the late 1960's to support for family planning in the 1970's; from virtually none to over 2,400 family planning clinics at present; from involvement by a token number of voluntary organizations to widespread participation by both government and private agencies. There have been changes in taxation and labor laws to decrease incentives for large families. Progress has been made, but in terms of impact on...the nation's rate of growth a difficult road lies ahead."

Impediments. Apart from the persistence of formidable cultural and economic impediments to population acceptance of birth control in LDC's (notably, the low status of women in the family and society and the backwardness of the countryside), the Embassies cite a number of program weaknesses which could help explain the lack of satisfactory progress.

-- The shortage of executive talent for family planning programs appears to be a particularly serious constraint (e.g., Egypt, Kenya, Ghana, Haiti, Iran, Malaysia, Nicaragua, Mali, Botswana, Nepal, Ecuador, Liberia). The critical role of administrative performance is noted both when, by its effectiveness, family planning programs have been successful, and when, by its ineffectiveness, they have yielded poor results.

> In Kenya, "the most obvious obstacle to family planning progress is bureaucratic lethargy, inefficiency, delay, and lack of planning and administrative capability within the MOH...**

A shortage of professional manpower is also handicapping some programs. The low priority of family planning in some countries contributes to this situation.

* This is in addition to the widespread and growing clinical and hospital system of delivering family planning services.

** MOH - Ministry of Health.

-- In countries where family planning services are channeled, by and large, through public health facilities, geographic distribution of these services is rather limited. Development of alternative rural delivery systems is high on the list of priorities in many program strategies.

> The most serious continuing deficiency of the Philippines' program is that the GOP efforts have been largely restricted to towns, and the program has not developed an effective rural outreach where 70 percent of the country's population lives.
>
> In Ethiopia, under the strategy of offering family planning as part of MCH health service, only 15 percent of the rural population can be reached.

-- The political sensitivity of the birth control issue, still evident in a number of LDC's, impedes vigorous implementation of the governments' declared family planning policies (e.g., Turkey, Morocco, Malaysia, Nigeria). This requires a "low profile" in organized family planning activities, for fear of jeopardizing government's relations with the Church, opposition parties, ethnic/religious minorities, and other politically influential groups.

Importance of social setting. Organized family planning programs have made valuable contributions toward fertility reductions in the 14 LDC's listed above. Nevertheless, Embassies in these countries also stress the importance of the social setting for widespread acceptance of small family norms. Embassy Kuala Lumpur, for example, attributes the declining population growth rate in Malaysia in part to rising educational attainment, women's increasing participation in the labor force, and rising age at marriage. Korea's success is credited, in large measure, to social and cultural trends accompanying rapid economic development and to cultural characteristics of Korean society. Thus, while the GOK family planning program has helped directly to reduce the birth rate, much of the success is "obviously attributable to non-program factors." Embassy Taipei offers a particularly thought-provoking observation about one of the most successful family planning programs.

"To what extent the birth rate in Taiwan can be reduced further, even with more personnel, better program direction, additional money, and new approaches, is still unknown. It is clear, however, that standing still will not solve the problem. Taiwan has gone through the first stage of family planning programming in which motivation of the ready-to-accept group was the main task. It has now entered the second and more difficult stage, in which the decline of fertility will depend primarily on reduction of family size and spacing of births. This is a new area in which Taiwan has little experience."

5. Foreign Aid to Population Programs

Embassy Nairobi does not agree that priority emphasis in U.S. foreign aid should be given only to the 13 LDC's which contribute most to world population growth. Kenya's economic and ecological realities, in the Embassy's view, qualify it for continuing and increased USG assistance, as the country's future is "very much linked to its ability eventually to control its population problems."

In countries where either birth control programs or USG assistance to them are sensitive issues, the Embassies usually prefer that USG aid be channeled through international--multilateral or private--agencies. This recommendation applies to three countries with explicit commitments to fertility reduction programs, namely, India,* Iran, and Sri Lanka. Also, indirect assistance is recommended to Taiwan, since its program may be progressing to the politically charged "beyond family planning" stage. USG support of surgical sterilization programs is specifically not advised in Colombia, Ecuador, and the Dominican Republic.

In a number of LDC's whose governments do not give high priority to family planning, Embassies suggest that USG and other donors support the development of the countries' usually limited health facilities.** Health infrastructure, in this

* Embassy New Delhi recommends expanded collaboration between the U.S. and India in research on human reproduction.

** In a number of African states, Special Population Assistance and Self-Help funds were used to support maternal and child health services, including a family planning component (Malawi, Rwanda, Swaziland, Zambia, Togo, Central African Republic (CAR), Mauritania). The Embassies consider this money well spent.

context, is regarded as the likely "vehicle" for eventual dissemination of family planning services (e.g., Brazil, CAR). Embassy Nairobi is also of the opinion that "an involvement in health care per se offers the USG the best chance ultimately to help the Kenyans to deal with a serious population problem." A somewhat broader strategy suggested by Embassy Ouagadougou (Upper Volta) would probably find support among most Embassies in Africa. It calls for (1) donor assistance in developing effective rural health and nutritional programs, based essentially on preventive medicine; (2) continued provision of information on population, statistics, and problems caused by increasing population density, with information in readiness on acceptable population programs. Embassy Brasilia also noted that U.S. can contribute to the "healthy evolution" of internal debate on population issues "through judicious and carefully monitored use of U.S. information and exchange programs."

Embassy Togo recommends flexibility in imposing donor requirements on foreign requests for assistance in the population field. Tanzania appears to provide support for this view. A UNFPA offer of vehicles for Tanzania's massive rural health project is tied to a requirement that the GOT ennunciate a policy of reduced birth rates. The Government will not accept assistance on these terms. Scandinavian donors in the country are said to have observed that Tanzania's need to take effective actions to reduce population growth rates is far greater "than any need to provide a stated population policy." Embassy Dar es Salaam appears to agree.

Multinational agencies. Intergovernmental agencies active in the population field did not receive unqualified praise. In Jakarta's view, the effectiveness of both UNFPA and IBRD, seems to be undermined by "centralized decision making, insufficient field mission discretion, inadequate country staffing, slow response capability, cumbersome/complicated implementation, insensitivity to feedback, and lack of interest in adjusting programs in midstream." In addition, it is stated that international organizations (notably in the UN system) often lack technical competence and follow cautious bureaucratic procedures, even in countries where governments have a high commitment to fertility reduction. (Embassy Rabat recommends renewed efforts to stimulate IBRD's active support of the GOM's program.)

Embassy Bogota expects some cautious rhetoric but not much action from IBRD and WHO, if they become involved in the local family planning program. The Embassy does not consider UNFPA support in Colombia particularly vigorous, imaginative, or efficient, in spite of some recent improvement. Bureaucratic problems are expected to inhibit UNFPA action, unless drastic reforms are undertaken. UNFPA's lengthy time frame for project study and decision and lack of demonstrated vigor in working together with countries to stimulate, develop, and implement effective family planning programs is not consistent, in the Embassy's view, with their stated policies or the critical nature of the (population) problem.

UNFPA and other UN agencies using the country personnel quota system, have produced "a very mixed bag" in respect to the qualifications of their technical experts. In Bangladesh, for example, senior members of the UNDP and some government officials are expressing disenchantment with the general expertise available through the UN system. More attention, in Dacca's view, should be paid in recruitment to professional qualifications, if the USG is to shift to multilateral assistance with confidence. Multilateral organizations, likewise, should demonstrate their ability to move funds and implement projects expeditiously when entering the population assistance field. The Embassy in Nepal has been "appalled" at times by the ignorance of population matters among certain technicians employed by multilateral donors. In its view, a series of inter-agency training programs on population might be useful for employees of UN agencies, in particular. One of the most important initiatives which Embassy Kathmandu recommends is an increased worldwide effort to improve understanding of, and commitment to, population issues within international agencies.

Private organizations are judged, by and large, to be very effective and receive Embassies' recommendation for continued support from the USG in fields in which they have a strong capability. Embassy Kathmandu finds most bilateral donor personnel reasonably knowledgeable on population issues. Embassy Seoul is of the opinion that "private intermediary groups such as IPPF and Population Council (New York) have been more effective in providing support than members of the UN system." In El Salvador, Nicaragua, and elsewhere, they have been particularly successful in initiating and carrying out small innovative projects, some of which the government has subsequently taken over on a large scale (El Salvador).

Coordination among donors is considered good in Thailand, Nepal, and the Philippines. It is "fairly well established" in Pakistan where an annual meeting of donors is convened by the GOP in Islamabad. In addition, the major donors represented in the country meet with the Government officials on a quarterly basis. Islamabad believes that the regular meetings of the IBRD-headed Pakistan Consortium have been helpful in keeping the population issue "front and center" in development policy in Pakistan. Embassy New Delhi reports, on the other hand, that Indian Consortium meetings, while showing great interest in family planning plans and progress, do not lend themselves to critical in-depth review of technical or organizational aspects of the program, other than for encouraging adequate budget.

Some governments do not wish a formal consortium of international donors in the population field (e.g., Nigeria, Tunisia). Prospects for one in the Philippines (which has effective coordination at working levels) is deemed remote, since the GOP insists on maximum domestic control of its program. Similarly, in Bangladesh, in spite of many donor requests, the GOB has not agreed to take an active donor coordination role. Also, both IBRD and UNDP representatives declined the job for fear of GOB's objection. In Kenya, where donor coordination has been very poor, the IBRD similarly "has virtually abdicated its role in this area."

Too much coordination may be counterproductive, in Manila's view, since it may increase tension between donors pushing for accelerated program performance and the local executive agency. In Bogota's view, excessive emphasis on coordination could inhibit the pioneering, innovative approaches of the private sector which have been essential for the population programs in Colombia.

Problems in coordination may arise from differences in basic approaches to the population problem. For example, in Bangladesh, AID strategy is aimed toward rapid expansion of delivery of contraceptive services. IBRD, on the other hand, attempts to address all parameters of the population control equation at once. Thus, while AID/Dacca views the coordination with UNFPA as good, its coordination with IBRD is deemed inadequate. Embassy Dacca recommends greater coordination between AID and IBRD in Washington. It also suggests that, in countries where AID is providing major population assistance, AID should be represented on the IBRD population project development team.

Embassy Jakarta thinks that U.S. can best cooperate with international organizations by encouraging them to re-examine their programming capacities and traditional project approach. Embassy Quito urges that the USG consider, and seek to have others consider, how each development project impacts on the desired family size of the affected households. Embassy San Jose believes that the USG should promote seminars, conferences, and dialogues between the various international organizations actively involved in development assistance, to exchange information and discuss policies and programs for lowering mortality and fertility.

Finally, in recognition of "the seriousness of the world population problem and [its] impact upon [U.S.] interests...," Embassy San Salvador recommends that all Foreign Service Officers receive a proper briefing on the magnitude of the population problem, its policy implications, and the USG initiatives in this area, prior to an overseas assignment. It also recommends the establishment of a position of Population Attache (to serve in selected LDC's), to ensure that the population dynamics receive "the attention afforded agriculture, defense, economics, and commerce in the staffing of [U.S.] Embassies." In a similar vein, the Ambassador in Tunis believes that the U.S. cannot discharge its obligations through material help alone. To assist a national family planning program to achieve self-sufficiency will also require a demonstration by the entire U.S. Mission of the seriousness with which the U.S. views the population problem.

TABLE 1

Family Planning Programs in Less Developed Countries, by Government Policy and Region, 1976

(Population data in thousands)

		Family Planning Programs			
Total LDC population, 1975*	2,874.036				
Centrally-planned economies (China, North Korea, Vietnam, Mongolia)	883,352	Programs to reduce fertility**	Programs in the interest of family welfare**	Private programs only	No organized programs
Developing market economies	1,990,684				
Countries in the survey					
Number	77	26	28	8	15
Population	1,828,028	1,274,972	395,294	66,994	90,768
North Africa					
Number	5	3	1	-	1
Population	79,841	60,794	16,792	-	2,255
Sub-Saharan Africa					
Number	29	3	13	2	11
Population	231,962	24,023	153,862	12,438	41,639
Asia					
Number	22	13	4	2	3
Population	1,223,344	1,092,552	73,971	9,947	46,874
Latin America					
Number	21	7	10	4	-
Population	292,881	97,603	150,669	44,609	-

* United Nations' coverage of "Less Developed Countries" excludes Temperate South America, included in the 2,874,036,000 figure. The population of Temperate South America is estimated at 38,747,000.

** Government and private.

Source of population data: United Nations, World Population Prospects, 1970-2000, as Assessed in 1973. ESA/P/WP.53. March 10, 1975. Medium variant.

Family Planning Policies and Programs, 1976

I. POLICY OF FERTILITY REDUCTION IN THE INTEREST OF NATIONAL DEVELOPMENT

1. Declared policy

*India
*Indonesia
*Bangladesh
*Pakistan
*Philippines
*Thailand
*South Korea
*Iran
Taiwan
*Sri Lanka
*Nepal
*Singapore
*Fiji

*Mexico
*Colombia
*Dominican Rep.
*El Salvador
*Jamaica
*Trinidad & Tobago
*Barbados

*Egypt
*Morocco
*Tunisia

*Kenya
*Ghana
*Mauritius

2. Policy in the making

(Papua New Guinea)

(Haiti)
(Costa Rica)

II. POLICY OF FAMILY PLANNING FOR REASONS OF FAMILY HEALTH AND WELFARE (explicit or de facto)

1. Family planning part of the health system; private programs in operation

*Malaysia
Papua New Guinea

*Ecuador
*Honduras
*Nicaragua
*Costa Rica
*Panama

2. Planned integration of family planning services into the health system; private programs in operation

*Turkey
*Afghanistan

*Brazil
*Venezuela
#Haiti

#Algeria

*Nigeria
*Ethiopia
#Zaire
*Tanzania
*Mali
*Sierra Leone
Togo
*Liberia
#*Botswana
#Swaziland

/over/

III. NO CLEAR FERTILITY POLICY

1. Some government family planning services available; private programs permitted

*Bolivia
*Paraguay
*Zambia
*Benin
*Lesotho

2. Private programs permitted

*Syria
*Jordan
*Peru
*Madagascar
Senegal

3. No organized programs

Yemen
Cameroon
Upper Volta
Rwanda
Mauritania

4. Evidence of increasingly favorable governmental attitude toward family planning services for non-demographic reasons

(Syria)
(Jordan)
(Madagascar)
(Cameroon)
(Rwanda)
(Senegal)

IV. PRO-NATALIST FERTILITY POLICY/ATTITUDE and/or GOVERNMENT HOSTILITY TO FAMILY PLANNING

1. Private programs permitted

*Argentina
*Uruguay
Guyana

2. No organized programs

Libya
Burma
Saudi Arabia
Malawi
Ivory Coast
Guinea
Chad
Somalia
CAR
Gabon

* Member of the International Planned Parenthood Federation (IPPF)
# No private programs
()Primarily classified elsewhere

ANNEX II

Development of World Political and Popular Commitment to Population Stabilization

The Task Force recognizes that our approach to world population issues must be based on mutuality and respect for the rights and responsibilities of other countries in developing their own policies and programs. Every country faces somewhat different problems whose solutions must accommodate to the realities, pecularities, and circumstances of that particular country. There is, however, a degree of growing global interdependence that makes uncontrolled population growth in any one country or area of the world a matter of concern for all.

We also recognize that there is no single solution, no simple solution, and no short-term solution to the population problem. It is one that calls for the combined talents of scientists, economists, doctors, educators, government workers, and private voluntary organizations. Above all, it calls for greater involvement of leaders and diplomats than there has been over the past several decades.

What we and others in the world community do to promote the effective development of poorer nations of the world will also have an important impact on the population problem. Therefore, it is not just our AID population program that is involved but our total AID program as well as all the other types of measures referred to in the Secretary of State's message to UNGASS in September 1975 and to UNCTAD in May 1976.

If we are to help persuade other countries as to the importance of taking adequate, timely steps to cope with excessive population growth, we must be fully persuaded ourselves. Our leaders, diplomats, and others in authority must not only be persuaded, but they must also know the facts about population growth, in order to be effective in encouraging leaders of other countries to take the required action. Instructions have accordingly been sent, most recently by the Secretary of State, to our Ambassadors and country teams in each country where population presents problems, requiring that our Ambassadors and their staffs be informed on population issues and that they find appropriate occasions to raise the matter in discussions with host country leaders. We have already arranged for special population briefings for our Ambassadors assigned to countries with population problems. We are also circulating

population information materials to the field and are introducing more population education attention into Foreign Service Institute training.

For purposes of organized presentation, the balance of this paper is divided into three sections: (1) How to increase effective action in countries already committed to population programs (i.e., countries that have a stated national policy on family planning and development); (2) How to increase acceptability and action in countries not now committed to population programs; and (3) How to develop greater commitment to world action on population both in the United States and abroad. It should be stressed at the outset that there is a wide range of commitment within each of the categories (1) and (2) above. Among the committed countries, for example, some are far more active than others, as brought out in the preceding section of this report.

1. Countries Committed to Population Programs

The committed nations include almost all of the countries of East Asia and South Asia plus a scattering of others in Central America (including Mexico), the Caribbean, North Africa, and in the Pacific and Indian Oceans. Since this group includes the PRC with over 800 million people, India with over 600 million, as well as other large developing countries like Indonesia, Bangladesh, Pakistan, Philippines, and Thailand, it means that almost one-half of the world's population live in developing countries whose leaders are committed to population policies and programs. This represents roughly two-thirds of the developing world.

Within the committed grouping, the U.S. has no influence over PRC programs (which have no outside support), relatively little influence in India and Mexico (where we have no direct bilateral programs but where we can assist through UNFPA, IPPF, etc.), but the U.S. does have considerable influence in other committed countries, especially those where U.S. AID programs, including family planning, are considerable.

AID's principal means to support population policies in these countries has been, and is likely to continue to be, related to supplies and supply systems. AID is also seeking to help improve demographic data, expand applied biomedical and social sciences research, improve information/education/communications programs in support of family planning, and extend training and education activities

related to population programs. The U.S. is also supporting measures affecting family planning, such as broad economic development, improved status of women, changes in laws and statutes (such as raising the legal age for marriage and incentives for smaller families), and better income distribution. These measures lend themselves to treatment (e.g., via USIS informational programs) pointing out the lessened potential for economic development given the impact of population increases on energy and food requirements, the environment, health, and other social services.

However, many leaders recognize that all these measures, significant as they are, will not help reduce population growth rates sufficiently to avert major disasters. Prerequisites for real success are likely to involve three approaches that are interrelated and have proved highly effective, as follows:

(1) strong direction from the top,

(2) developing community or "peer" pressures from below, and

(3) providing adequate low-cost health-family planning services that get to the people.

With regard to (1), population programs have been particularly successful where leaders have made their positions clear, unequivocal, and public, while maintaining discipline down the line from national to village levels, marshalling government workers (including police and military), doctors, and motivators to see that population policies are well administered and executed. Such direction is the sine-qua-non of an effective program. In some cases, strong direction has involved incentives such as payment to acceptors for sterilization, or disincentives such as giving low priorities in the allocation of housing and schooling to those with larger families.

Of particular significance right now is India's consideration of involuntary sterilization. Some argue that these methods are morally reprehensible, but others maintain that they are more humane than allowing current population growth rates to visit disaster on millions of people, which might be the case if hard-line measures are not adopted. Some may argue that there are many practical obstacles to

involuntary sterilization programs (inadequacy of medical, legal, and administrative facilities), and others point out that involuntary programs, like Gresham's Law, may drive out current voluntary programs. On the other hand, proponents of involuntary sterilization argue that high disincentives tend to prejudice the children of parents with three or more children, whereas involuntary sterilization penalizes the parents. Whatever our reservations may be on this subject, it is important that U.S. officials avoid public criticism. Population policies are a matter for each country to decide for itself in terms of its own circumstances and perceived needs.

As to (2) above, there are a number of innovative approaches, like "wives'" or "mothers'" clubs in Korea and Indonesia, which are designed to popularize family planning at the village level and to create peer pressures within communities for limiting the size of families. These approaches should be encouraged and shared with other countries. In this connection, we welcome movements in many countries to strengthen the local communities--usually the village--and to create within that village a spirit of social and economic cooperation. Among many other advantages, family planning has a better chance of success when it is rooted in community life and when people can see within their own visible horizons how limiting family size improves health and economic prospects for everyone in that community.

The very permanence of the community is an important consideration. National governments come and go. Individuals come and go. But communities go on forever. Since population programs must continue for many years to take real effect, a community-wide approach will ensure longevity of programs among new generations. A solid community organization also provides effective means for group involvement, as well as for making family planning services locally available and for monitoring and encouraging their use.

A third promising way of promoting effective population programs is to combine family planning with health and nutrition in a single integrated structure with maximum outreach at minimum cost. Success of this approach, which is being increasingly adopted by committed countries, depends to a large extent on the quality of paramedics (health workers) and midwives (including auxiliary) and

their ability to win the confidence of villagers. Once this is achieved, paramedics and midwives can, among their other duties, effectively extend personalized family planning advice. It should reach women when they have their very first child at which time spacing of children should be strongly recommended. Thereafter, personalized advice can be extended on all available means of contraception, including sterilization, the final contraception, when desired completed family size has been reached, as well as medical termination of pregnancy where it is legal and desirable.

Two important reservations should be mentioned in regard to the integrated approach: (1) In several countries where family planning now has greater outreach than health services, family planning may initially suffer through full integration with health services; (2) Low-cost health services still require professional medical backup. There should ideally be enough doctors and professional nurses available in rural areas to handle cases referred to them by the paramedics and midwives, and to perform those aspects of contraception that require higher medical skills. Moreover, any attempt to by-pass the medical profession is likely to incur their opposition to the low-cost integrated system.

2. Countries Not Committed to Population Programs

LDC countries uncommitted to population programs include most of Africa, Latin America, and the Middle East, with a combined population of about three-quarters of a billion people. Population policies of these nations range from the pro-natalism of a few to the non-commitment of most of the others, where, in varying degrees, family planning is tolerated or even encouraged. Abortion is generally abhorred, and sterilization disfavored.

The relative lack of concern these countries reflect on population issues can be explained by a variety of factors such as:

(1) no perceived need to limit population growth;

(2) or, if there is a perceived need, wishful thinking that economic development will solve the problem;

(3) belief that a large family is necessary for old-age security or to meet needs for labor at certain points of farming cycle;

(4) preoccupation with other, more immediate, issues;

(5) religious influences; and

(6) ignorance as well as racialism, tribalism, and traditionalism.

To the extent family planning is identified with the Westerm world, particularly the United States, there are even greater inhibitions in some countries toward family planning. This factor may be particularly noticeable in international conferences where Third World countries tend to combine against the West, against capitalism, and in favor of the "New International Economic Order." It thus becomes particularly difficult to raise anything smacking of "birth control" in such international conferences, where Communist countries are only too prepared to line up with the Third World against the West, even though some of the Communist countries practice stringent birth control.

It follows that our efforts to promote family planning amongst uncommitted countries must be fine-tuned to the particular sensitivities in each of those countries. This serves to underline the important role of our Ambassador and his or her country team in each LDC country in terms of advising Washington on how commitment can be best achieved in terms of the particular circumstances of that country and being alert to take timely initiatives on their own to further these objectives.

A number of conclusions can be drawn with regard to countries whose governments do not officially favor or promote family planning:

(1) Terminology: use of such phrases as population control or birth control is inadvisable, and in some cases resented, especially in Africa where they may have genocidal connotations. Family planning or "responsible parenthood" are generally acceptable terms, with emphasis being placed on child spacing in the interests of the health of child and mother.

(2) Development: anything that increases awareness, especially amongst leaders, of how excessive population growth detracts from national development will advance the cause of population policies. It would be especially helpful if the World Bank and UNDP, as well as donor countries having close relations with developing countries, could find suitable occasions to convey specifics to LDC's showing how population growth is a drag on development in their countries. Our Ambassadors and Washington leaders may also have suitable occasions to make these points effectively. Computer projections of demographic and economic information as well as Census Bureau presentations can be made available to the governments of developing countries and to their media services in some cases.

(3) Education: closely related is the fact that educating promising LDC officials, scientists, and technicians in demography, economics, and other subjects related to population growth and development will be a sound long-term investment. Reduction of illiteracy, especially of women, is of special importance, as are national education programs and curriculae relating to basic population and health education.

(4) Primary health services: this subject has been treated in a section above, but it has particular relevance in countries unwilling to embrace family planning except in the context of health and nutrition. Since this is rather generally the case amongst the uncommitted countries, we would do well to place considerable emphasis on this approach in seeking to engage them in family planning. It is an approach that places family planning in a most acceptable context, and is particularly cost-effective where countries have not yet launched family planning programs.

(5) Working through international organizations and private groups: support of family planning in uncommitted countries will normally have to be through international organizations like UNFPA and WHO and private voluntary organizations like the IPPF. International organizations should be encouraged to work family planning content into their assistance programs insofar as possible and particularly in countries whose sensitivities make a direct approach on population planning inadvisable. Private voluntary organizations have played an invaluable role in family planning, including their support for small groups interested in family planning before governments in those countries were involved.

(6) Status of women: in many of the uncommitted countries, male machismo, inhibitions about discussing sex issues, and the subservient role of women combine as major obstacles to family planning. There must be the creation of opportunities for women beyond the rearing of children. Accordingly, we should discreetly strive to lend every possible support to movements in the LDC's for the improved status of women, not just within the family but in community and national life as well.

(7) Strategy for developing an effective population program: this has been proposed by our Ambassador to Ethiopia. He describes a possible multi-year program involving cooperation with international organizations in moving Ethiopia from its present non-committed position to one of government commitment, with a generalized description of each phase in the re-orientation process. Such an approach may be helpful in a number of uncommitted countries in setting new directions for the future.

(8) Mutual reinforcement within regions: we should see that positive statements on population issues by respected leaders are picked up and played back among neighboring countries. While direct programming may not be possible due to the sensitivities of the population issue, USIA could explore cooperative arrangements with private or multilateral organizations of good standing in the countries in question. Leaders of developing countries committed to population programs should be encouraged to share their thoughts and concerns on population growth and their successes in dealing with it in discussions with the non-committed. Wider publicity on the affects of successful family planning programs must be given to encourage others.

3. Developing Greater Commitment at Home and Abroad

Virtually all countries have population problems of sorts, and the United States is no exception. Fortunately, there has been a drop in the U.S. birth rate to parallel the drop in the death rate so that our rate of increase was only .81 percent for 1975 including immigration. But we do have distribution problems, and our larger cities with declining tax bases in particular are showing strains in providing services. Some areas have serious pollution problems. Many are faced with mounting crime rates.

Rapidly growing populations in some countries have tended to spur emigration to the U.S. This includes illegal immigration which probably exceeded 800,000 in 1975 or almost double the legal immigration that year. In 1976, the Senate took legislation under consideration which would establish penalties on U.S. employers who knowingly hire illegal aliens. Similar, tighter legislation is already contained in the Rodino Bill on Immigration approved by the House.

U.S. concern over population issues, nevertheless, relates primarily to how excessive population growth rates around the world create dangers of famine, environmental degradation, social unrest, political turmoil, and war that could involve the entire planet. This must be everyone's concern, and mankind must be committed to corrective measures before it is too late.

Even though the Bucharest World Population Plan of Action calls, among other things, upon countries to develop national population policies and programs, the United States has no national program of its own. This detracts somewhat from our effectiveness in urging others to develop programs. On the other hand, we can point to a de facto policy in the U.S. supported by legislative action, federal funding, and recent Supreme Court decisions. Also important are many effective family planning activities in the United States and certain steps being taken here which have wide relevance in other countries, such as courses in population studies that were recently introduced in the Baltimore Public School System or the integrated health delivery system of our Frontier Nursing Service which operated under conditions similar to those in many developing countries. An excellent film has been done on the Frontier Nursing Service which should be widely distributed abroad.*

In order to obtain the support of U.S. citizens for our involvement in international population programs, it is important, as stated in NSDM-314, that they recognize how excessive world population growth can affect domestic problems including economic expansion as well as world instability.

---

*The Federal Interagency Committee on Education is now preparing a series of recommendations for the Secretary of HEW on how to build a system of population education both in the schools and among the public, and how the Federal Government can support such a system.

While many people fail to grasp the vast dimensions of the population problem and its impact on their lives, there is a body of opinion that tends to see the problem as so vast and complex that it is beyond man's capacity to solve. Our position must, therefore, always be balanced between (1) the many dangers in current population growth rates and (2) what can be done about it. We must stress that the world stage has at long last been set for more effective action by the nations of the world; that many countries have drawn up, or will soon draw up, population policies and programs; and that family planning has enlisted the active support of many leaders and dedicated people, especially women, who have a particular stake in successful family planning programs. As a result of these developments, as well as other factors on the changing world scene, birth rates are generally tending to go down in many areas.

On the other hand, we should not err in the direction of over-simplifying the problem or suggesting that it is amenable to any short-term solutions. Obstacles are many. The task is formidable. It will require the concentrated, sustained efforts of all countries and international organizations, as well as the commitment of millions of dedicated people, if mankind is to be spared disaster.

This is our message.

In projecting our position, we must convince people at home as well as abroad. Promotional aspects of our job cannot be overstated. A Presidential statement on population policy reflecting the thrust of NSDM-314 would be most helpful, particularly in enlisting support and understanding of the American people.

At home, it involves gaining the attention and support of the media, of Congress, of organizations, and of groups of concerned citizens and including the subject of population in official publications and speeches, especially those of national leaders.

Abroad, it takes the form of private conversations with leaders and others (involving our own leaders, diplomats, and other representatives), of getting international organizations like IBRD, UNDP, WHO, and UNICEF, as well as other countries, to speak to the issues; of USIA ensuring

that our message comes through effectively by radio/TV, press, exhibits, books, panphlets, slides, and films as well as through education programs, lectures, and workshops. We should press for the inclusion of population and population-related issues, as appropriate, on the agenda of the UN and other international gatherings related to foreign assistance, development objectives, and resource utilization. Often this is best done in close cooperation with developing countries which have their own national population programs.

In all of these approaches, we must be selective, bearing in mind the danger of population programs otherwise being seen as serving primarily our interests rather than those of other countries. That is why emphasis in the preceding paragraph is on private conversation and on getting international organizations and other countries to get out in front. This is particularly true with regard to international conferences involving the LDC's where population issues are relevant. In those circumstances, we should encourage LDC representatives to take the lead. Credit for accomplishment should be theirs, not ours.

We have learned from experience that the United States, though it must retain a leadership role, cannot solve the problems of other nations. It is up to those nations to take action, but we can help those countries' problem-solvers.

ANNEX III

U.S. POPULATION-RELATED ASSISTANCE

Analysis and Recommendations

A.I.D.
Washington, D.C.
April 1976

Approved For Release 2003/08/08 : CIA-RDP79M00467A002500120004-8

POPULATION ANALYSIS

Summary

Rapid population growth in developing countries continues to exacerbate the already difficult task of improving the welfare of millions living at or near subsistence. While birth rates in developing countries have begun to fall, death rates have also declined, and resulting annual rates of natural increase of around two percent threaten to double the population every thirty-five years or so. The basic question of this analysis is how to achieve the greatest additional voluntary reduction in fertility at a given program cost in those LDC's wishing to slow population growth. We recommend a "package" approach involving increased levels of Title X assistance and sharply increased attention to the potential impact on fertility of other development programs or policies.

Fertility control remains a sensitive subject; three caveats on this paper are in order. First, it must be seen in light of AID's assistance objectives as delineated in our legislation, which are in turn grounded in the mutual interests of LDC's and the U.S. Most LDC's take their fundamental development objective- to be improving individual levels of well-being particularly among the rural poor -- by encouraging broader participation in development, helping increase supplies of key

goods and services, supporting their equitable distribution, and limiting the numbers who must share (through family planning). This particular paper, however, addresses one aspect of AID's programs -- their impact on fertility. The Agency considers voluntary fertility reduction as only one means, albeit an important one, for achieving improvements in individual well-being. This view is compatible with the view of many LDC's as expressed at the World Population Conference, the International Women's Year Conference, and other public fora -- and with the implicit priorities reflected in development policies and programs of some LDC's whose public pronouncements on fertility have been limited. The paper concludes that AID-assisted family planning services and development programs can all affect fertility. This does not suggest, however, that AID programs with little or no fertility effect should be downgraded, for such programs may be justified on independent grounds.

Second, the paper does not seek to prescribe any particular approach to reducing fertility for any particular country. AID provides population assistance only when requested, firmly believes that ultimate responsibility should rest with the LDC concerned, and implements any assistance in a collaborative style.

Third, the paper does not address whether the U.S. practices what it preaches in terms of population policy. The U.S. lacks

an official population policy, but does have many of the programs (public or private) discussed here, and the average family size implied by current U.S. fertility rates is slightly less than two children.

* * * * *

Population growth rates reflect the sizes of individual families. Couples need not affirmatively decide to have a child, but they must affirmatively decide to practice family planning to postpone pregnancy either temporarily or indefinitely. Consciously or unconsciously they weigh the pros and cons, as they see them, of another child against the pros and cons, as they see them, of available means of family planning. Their attitudes toward family planning depend on the type, cost, and accessibility of the family planning services available and on the extent to which they accurately understand those services. Their views on the desirability of a child are more complex, and depend largely on the social, cultural, economic, political, and medical milieu.

The number of children parents actually have includes:

(1) the minimum desired number of children that parents would want even if the best possible family planning services were available;

(2) any additional "insurance" births they may want to insure survival of the desired minimum;

(3) any extra births they don't really consciously seek.[1/]

Providing better family planning services and information is perhaps the most obvious way to tip parental decisions in favor of family planning. Better services and information can avert extra births that couples do not affirmatively seek. They can also help reduce insurance births as wider spacing of pregnancies works to improve the health of existing children. And they can indirectly influence the minimum number of children parents seek; as services change family size now, they help modify future social expectations on appropriate family size.

Thus most population assistance and domestically financed population programs have concentrated on developing and extending better family planning services and information. Over the past decade AID has devoted some $750 million to population assistance, primarily to improve and extend services and information. While it is difficult to quantify their demographic impact precisely, available evidence shows that providing good services has helped siginficantly to reduce birth rates, particularly in Asia. The exact role of AID is difficult to pinpoint, of course. But where AID has supplied a large part of the wherewithal needed to develop and extend family planning services and information or

---

1/ No one pretends, of course, that sharp lines divide these three categories of births. But they do reflect reality and they also help to clarify analysis.

supportive measures, it can claim considerable credit for subsequent drops in birth rates. (AID programs have also worked to stimulate the gathering of more accurate demographic data, inform leaders and policy makers on the urgency of population problems, and encourage the development of needed institutions and skills, etc.)

Since services are as yet available to only about 15% of most LDC populations, further extension of better services should bring substantial further birth rates reduction.

But family planning services and information alone may not suffice to bring birth rates down to current LDC target levels, much less to stable-population levels. That would require an average family of only slightly more than two children. As emphasized at the World Population Conference and elsewhere lately, for socio-economic reasons many parents may feel they want three, four, or more children at a minimum even when safe, effective, acceptable, and affordable family planning services are made available. A small-scale farmer in India may want several children, particularly sons, to provide reliable labor at planting or harvest, to support him during old age, and to dispose of his body according to his religious rituals. The illiterate wife of a Latin campesino may be content to keep bearing and rearing children; it was what she was always expected to do. And so on. AID believes development policies

and programs can be tailored to change the socio-economic milieu to encourage smaller families, thus effectively complementing better family planning services and information. Indeed such a package approach involving both development programs and policies and improved family planning services and information may be the most effective way to accelerate declines in birth rates.

Development policies and programs that can encourage smaller families include:

-- Policy statements favoring small families and opinion leaders' support for family planning.

-- Laws and regulations raising the minimum age of marriage and easing access to and lowering the cost of family planning services.

-- Increased education for women.

-- Increased female employment in non-menial occupations that compete with continual childbearing, bearing in mind the need to assure that children, particularly among the poor, can be cared for.

-- Increased economic incentives for smaller families, whether for individuals or whole communities.

-- Rural development promising higher incomes and more egalitarian distribution.

-- Improved rural organization like multi-purpose cooperatives and other such village organizations that can be used for a variety of related purposes like increasing income earning opportunities, improving health, or encouraging family planning.

The importance of improving the status of women and increasing their opportunities deserves special mention.

PROGRAM RECOMMENDATIONS

Focusing on improving the well-being of the rural poor will help generally to lower fertility, while lowering fertility may in turn help improve living conditions particularly in poor, crowded, rural areas. Thus reducing fertility may itself call for about the same "package" of development policies and programs that seem most promising as means of generally improving welfare, though some qualifications on that statement must be made.

The following are our basic recommendations for both Title X population assistance and other AID and PL-480 assistance as it may affect fertility.1/

A. Title X Program Directions

Since the primary purpose of Title X population assistance is to encourage voluntary reduction in fertility, decisions on allocation of these Title X funds should be based on the cost effectiveness of alternative approaches to reducing fertility, including (a) more and better family planning services; (b) more and better family planning information; (c) exploration of the links between fertility and the development process; (d) provision of population-related components in broader education, health, nutrition, rural development or other programs; and (e) other appropriate measures designed primarily to limit fertility. At present we believe somewhat higher Title X funding levels, perhaps around $200 million,

---

1/ As indicated below, we do propose using non-Title X funds to affect fertility, inter alia, as appropriate given other objectives.

could be justified over the next several years depending on LDC interest and absorbing capacity, though we need to improve data and refine statistical methodology in order to make a better case for precise levels. With that in mind, we suggest the following program directions within the six functional categories of Title X population assistance.

Category 1: Demographic Data

--- Place less emphasis on financing broad-based but relatively undetailed censuses in the future.

--- Moderately expand efforts to develop more complete and detailed demographic data at least on parts of populations to permit more accurate estimates of the demographic impact of various programs.

Category 2: Population Policy

--- Moderately expand LDC-based research on the linkages between fertility and various aspects of development, particularly including:

a) female education of various types and levels;

b) female employment;

c) health (especially of children);

d) nutritional status of women and children;

e) incentives/disincentives to encourage smaller families;

f) income growth, distribution, and rural development (focusing specifically on food);

g) laws and policy statements supporting family planning;

--- Moderately expand "population impact" analysis and other measures to encourage broader understanding of the development implications of population growth and the potential for bringing development programs to bear on fertility.

--- Moderately expand pilot projects and experiments in areas a) - f) above, providing technical assistance or financial support. (Title X or other AID funding for expansion of pilot programs in these areas would depend on such things as estimated cost-effectiveness, the extent to which lack of funding constrains program expansion, and competing demands on funds.[1])

Category 3: Research

a) Bio-medical Research [2]

--- Moderately expand projects to field-test promising new family planning methods.

--- Moderately expand research to develop new methods (particularly once-monthly methods and better and more reversible methods of male and female sterilization) and research on side effects of available methods, particularly pills.

--- Moderately expand research on the relationship between nutritional status and fertility.

b) Operations Research

--- Sharply expand LDC-based research on the comparative effectiveness of alternative approaches to family planning services and information, focusing particularly on basic, low-cost, village-based distribution with short start-up times.

--- Sharply expand LDC-based research on what services, health auxiliaries, and laymen may be able to provide.

--- Sharply expand research on whether or under what conditions village-distribution schemes using low-level health auxiliaries or lay personnel can be established without much clinic backup.

1/ As noted elsewhere, of course, Title X funds would not be used for programs whose primary objective is not reducing fertility, except for the parts of such programs that might directly affect fertility.

2/ Subject to legislative restrictions on research involving abortion.

--- Moderately expand research on prospects for LDC production of contraceptives and other family planning supplies.

Category 4: Family Planning Services

We expect the major focus of Title X population assistance to continue to be on extending better family planning services; within that focus, we shall give priority to providing more low-cost services for the poor, particularly in rural areas where the vast majority still lack any but traditional services. We shall:

--- Encourage provision of a variety of family planning methods, particularly pills, condoms, and sterilization.

--- Sharply increase efforts to help establish and expand village-based distribution of family planning services in rural areas particularly through low cost systems relying on health auxiliaries and laymen and promising short start-up time.

--- Encourage integration of health, nutrition, and family planning services wherever sensible, taking care to encourage movement on either the health or family planning front where simultaneous movement may be very difficult.

--- Seize opportunities to "piggyback" family planning services on existing delivery systems, particularly clinics, where they are available (e.g. some Latin countries).

--- Encourage allocation of health funds to the establishment of low-cost delivery systems reaching into rural areas that could add in family planning where that approach seems most promising (e.g. some African countries).

--- Encourage provision of appropriate contraceptives through private channels (e.g. midwives) or commercial outlets like pharmacies or small shops.

--- Work with intermediaries, public-funded programs, or both depending on potential effectiveness.

In terms of country priorities, we take our primary objective to be getting family planning services started in developing countries. We will, of course, give careful attention to encouraging those countries to assume total responsibility for their own programs, including their major contraceptive requirements.

Category 5: Information, Education, and Communication

--- Where broad-based family planning awareness campaigns have not been undertaken, we would encourage those; but since many countries have undertaken such campaigns, we expect relatively less emphasis in this area.

--- Where basic awareness exists, fine-tune existing IEC efforts so they are:

a) country and culture specific;

b) informative on each specific method of family planning;

c) related to personal needs and aspirations;

d) focused considerably on the interface between village family planning worker and village client;

e) reliant on relatively inexpensive media with broad out-reach that require little reading (e.g. radio);

--- Sharply expand operational field testing and collaboration with other agencies, such as UNESCO and UNDP to better determine which combinations of the many modern and traditional media are more efficient, effective, and suited to the special and evolving needs of differing countries and family planning programs.

Category 6: Manpower and Institutional Development

--- Sharply expand efforts to help train health auxiliaries or laymen for village-based distribution.

--- In countries having enough basic family planning workers at present, focus on filling specific institutional and personnel needs.

--- Moderately expand efforts to strengthen planning and management capacity at all program levels.

B. OTHER AID PROGRAMS AND PL 480: PROGRAM DIRECTIONS RELATING TO FERTILITY

Other AID programs -- in food and nutrition (and broader rural development), in education, and in health -- can affect fertility indirectly but significantly as discussed above. Except for low-cost health systems designed to provide an integrated package of health, nutrition, and population services to larger proportions of LDC populations, the primary objectives of AID's other programs do not include fertility reduction, though that may be an important secondary result. It is expected that due weight will be given to any secondary impact on fertility when the benefits and costs of possible programs are considered, though final funding decisions will of course depend on all benefits and costs. It should be stated specifically, however, that non-Title X population funds can be used to explore links between fertility and development and assist in planning, implementing, and evaluating programs designed to affect fertility.

Specific suggestions follow. We emphasize, however, that in each are additional LDC-based research is needed.

Food, Nutrition, and Rural Development

--- Give increased attention to projects that will help elucidate and take advantage of the linkages between these program areas and fertility, particularly focusing on the very poor. (It is particularly important to have an over-view of the problem in order to plan the best possible combination of individual projects that will act in coordination to improve well-being, lower fertility, etc.)

--- Give increased attention to those programs helping reduce unequal distribution of income and other goods and services.

--- For rural development as a whole, give increased attention to a "package" of policies designed both to foster production and slow fertility growth as consistent with LDC objectives and preferences and with managerial capacity.

--- Give increased attention to projects which encourage community-based organizations and local managerial capability.

--- Give increased attention to potential fertility effects of any proposed redistribution of the land.

--- Give increased attention to the use of community or personal incentives (relevant for either AID or PL 480; major additional attention should be devoted to this area).

--- Give increased attention to ways of fostering rural development that discourage traditional forms of child and female labor.

--- Give increased attention to ways to encourage profitable employment for women in non-traditional, non-menial occupations.

--- Give increased attention to the problems of planning administering, and evaluating multi-purpose or "package" programs that may affect fertility inter alia.

Particularly on Nutrition:

--- Encourage integration with health and family planning services where appropriate.

--- Encourage programs with direct impact on lower fertility, such as promotion of breastfeeding.

Education

--- Give increased attention to raising the number of female beneficiaries in all programs (especially where males outnumber females significantly), bearing in mind other benefits and costs of such programs.

--- Give major attention to expanding basic education for girls as well as boys.

--- Encourage incorporation of messages on the benefits and methods of family planning into formal and non-formal education programs of all types -- in schools, through rural extension work, through clubs, etc.

Health

--- Encourage development of integrated health, nutrition, and family planning services where appropriate (either in one organization system particularly at the village level or at the planning level) for the majority. Also encourage integration at the planning level, to assure efficient coordination of all programs that may substantially affect health and fertility.

--- Give major attention to maternal and child health.

Country Priorities

Obviously the same type of program will not do for all countries; thus, our general policy and program strategy must be adjusted considerably for a given country, and an approach developed that makes sense in that country. The overall shape

of all AID programs actually operating will depend on what countries we actually assist. Country allocation decisions naturally reflect both U.S. economic and political interests and prospects for meeting program objectives -- in this case, reducing world fertility.[1/] Here we propose to give only rough guidelines as to the countries in which AID may concentrate its population-related assistance. Special concern exists for thirteen countries excluding China who contribute most to world population growth: Bangladesh, Brazil, Colombia, Ethiopia, Egypt, India, Indonesia, Mexico, Nigeria, Pakistan, Philippines, Thailand and Turkey. But AID does not operate major bilateral population programs in about half of those countries at present; nor can we mount massive programs through intermediaries of the scope, design, and vigor we would want. Thus the Agency is also determined to pursue opportunities in a limited number of other countries interested in reducing fertility where prospects seem bright or where unusually good opportunities exist for development prototypes of programs that may also prove helpful in other countries. We are continuing our analysis of program prospects, requirements, problems, etc. in order to refine our list of country recipients, assuring adequate program focus, and expect to make considerable further progress in this area in the next several months.

1/ It bears emphasizing that reducing fertility is only one of AID's objectives under the mandate -- and that it is viewed as a means of facilitating per capita improvements in welfare.

U.S. POPULATION-RELATED ASSISTANCE

Analysis and Recommendations

Table of Contents

THE PURPOSE

AID has been asked to evaluate experience with alternative approaches to reducing fertility in LDC's, to identify promising approaches for the future, and to suggest directions for U.S. population-related assistance in the next decade. The Agency gives continual attention to program directions; the analysis presented here builds on substantial earlier efforts.

In reviewing this paper, it is crucial to bear in mind the caveats presented above, particularly noting that this paper focuses on only one aspect of AID's program -- its impact on fertility. AID's overall purpose, like that of many LDCs, is to improve the well-being of the poor; limiting population growth is only one means, albeit an important one, to that end. AID does not seek to impose any course upon an LDC, and provides population assistance, like other assistance, only when asked.

CURRENT POPULATION GROWTH

Rapid population growth in developing countries seriously exacerbates the already difficult task of improving the welfare of millions who already live at or near subsistence. Such growth creates additional demands on already scarce resources and impairs the already precarious health of women and children who share present and future development burdens. Worldwide, population growth generates increasing environmental pressures that may be serious now or eventually.

And it contributes to international political and economic disruption. In developed countries population growth has abated recently, averaging about 0.71 percent annually, with birth rates at about 16.3 per thousand and death rates at about 9.2 per thousand.1/ In developing countries, however, the picture is different. While birth rates have begun to fall in many countries recently, the rates still average about 32.7 per thousand; death rates, which have also declined dramatically over the last two decades, still remain at about 12.8 per thousand.2/ Resulting population growth averages about two percent annually.3/,4/ This growth rate implies a doubling of LDC population every thirty years or so, at least until birth planning or increasing disease and malnutrition intervene. Moreover, the task of containing population growth through birth planning is complicated by the "built-in momentum" of a growing population: with a high proportion of young people who have yet to bear children, growth would inevitably persist for many years even if the two-child family should suddenly become the norm. Thus, though an encouraging start has been made in reducing fertility, much of the task remains ahead. Development programs over the next decades will inevitably have to consider population growth; the question is how much, and what the funding implications will be.

1/ North America, Europe, excl. USSR, Oceania, Japan.
2/ Latin America, Africa, Near East, Asia incl. PRC but with Japan among the developed countries.
3/ These rates assume our best estimates on the PRC. Without the PRC, birth rates would be about 39.1, death rates about 15.2, and the resulting rate of natural increase about 2.39.
4/ World Bank birth rates average 28.1 per thousand, death rates average 11.8 per thousand, and the resulting rate of natural increase is 1.63 percent annually.

THE PROBLEM

Population growth rates reflect the size of individual families.

Couples need not affirmatively decide to have a child, but they must affirmatively decide to practice family planning, whether they just want to postpone pregnancy or whether they want to end their childbearing.[1/] Consciously or unconsciously they weigh the pros and cons, as they see them, of a child against the pros and cons, as they see them, of available means of family planning. Their attitudes toward family planning depend on the type (hopefully reflecting both cultural acceptability and bio-medical concerns), cost, and accessibility of the family planning services available and on the extent to which they accurately understand those services. Their views on the desirability of a child are more complex, and depend largely on their social, cultural, political, economic, and medical milieu.

Thus, the number of children parents actually have includes:[2/]

(1) the minimum desired number of children that parents would want even if the best possible family planning services were available;

1/ Couples who wish to have a child for whatever reason (including sub-fecundity) will plainly not be interested in family planning to prevent pregnancy.

2/ No one pretends, of course, that sharp lines divide these three categories of births. But they do reflect reality and they also help to clarify analysis.

(2) any more "insurance" births they may want to insure survival of the desired minimum;

(3) any extra births they don't consciously seek, but which result from miscalculations, laissez-faire attitudes, casual assessments of long run costs and benefits, etc.

Minimum desired family size depends on all the economic, social, cultural, and personal influences on the family. It does not depend directly on the availability of family planning services, though it is likely that the successful use of services available now may well influence future attitudes and expectations on appropriate and acceptable family size. Attitudes on minimum desired family size can also be directly influenced by information and education programs specifically designed to influence them. And development policies in any number of seemingly unrelated areas can change minimum desired family size by changing the economic, social, cultural, and personal circumstances of the family in such a way as to make smaller families a more attractive option.

Insurance births can be reduced by improving child health -- by providing better health services, better nutrition and even better family planning services (since wider spacing of pregnancies greatly improves child health where mothers and children are ill and poorly fed).

Extra births, which may be numerous, can be greatly reduced or even eliminated by providing acceptable, affordable, and accessible family planning services and appropriate information.

The basic question of this particular paper is how to achieve the most voluntary reduction in family size and fertility with limited resources, bearing in mind that both LDC and AID objectives are of course much broader than this, as discussed above. But many LDC's receiving U.S. aid have low target birth rates; for argument's sake, we take their ultimate demographic objective to be a stable population.1/

Providing better family planning services -- effective, safe, affordable, and accessible -- seems the simplest way to tip parental decisions in favor of family planning. In the few countries that have such services on a wide scale, birth rates are falling -- not to stable population levels yet, but far below their recent high levels.2/ The cost-effectiveness of such services depends on whether they are used efficiently, on how many children the users have, on how many fertile-age couples are users, and so

---

1/ A stable population requires essentially a two-child family -- or a "net population rate" of one (meaning each woman has, on average, one daughter).

2/ Examples of countries where birth rates have declined from high levels: Taiwan (23 per thousands population), Costa Rica (28), Korea (29); Colombia (32). Several other countries, including India and Thailand, now have birth rates in the mid-30s. Sri Lanka and the State of Kerala in India also have low birth rates.

on.[1] So far, really good services -- i.e. safe, effective, affordable, and accessible -- do seem to be used extensively and by people who otherwise probably would have had several more children.[2] Thus good services probably represent the cheapest approach to reducing birth rates so far. And a good many more people in LDC's stand ready to use good services. It is only sensible to provide them with such services, which need not be costly, as a start.[3] That much is clear. Thus AID has devoted most Title X assistance, totaling some $750 million over the past decade, largely to improving and extending family planning services (including information), and plans to continue to do so.

But family planning services and information alone will probably not suffice to reduce birth rates to near stable-population levels.[4] Essentially, this would require an average

1/ The demographic impact of services depends on the proportion of fertile-age couples using them ("prevalence"), on the number of children those users have ("parity"), on service effectiveness, etc. Parity data are poor, but available prevalance data suggests birth rates do fall as prevalence rises, especially over 20%. Some people believe, at present levels of acceptance and birth rates, a two percent increase in prevalence leads to about a one-point decline in the birth rate, through this relationship is very tentative. Prevalence in most LDCs, is under 15%; such countries have few good services on the whole.

2/ This is particularly true when both conceptive and post-conceptive services are made available, data seem to suggest.

3/ The question of where acceptance rates may peak is discussed below.

4/ Most family planning experts believe that population stability would require prevalence on the order of 60-70%, based largely on developed-country and Asian experience.

family size of only slightly more than two children. Making family planning as easy as possible can certainly eliminate unwanted pregnancies and help reduce "insurance births" as wider spacing of pregnancies improves child health. And through their influence on social expectations over time, services may encourage people to want fewer children as a minimum. But services alone may not much reduce the minimum number of children parents want. That may be no problem if most parents would be content with two children. But if many parents want three, four, five, or more children even when good services are available, then it will be essential to combine services with development policies and programs that also encourage smaller families.

No one really knows what the situation is in fact. In the few places (including some poor, rural areas primarily in Asia) where good services are really available, indications are that around a third of the couples, mostly with 3-4 children, may use them.1/ This suggests that extending good services further can indeed reduce family size sharply, and certainly good services should be provided as rapidly as possible. But historical evidence also suggests reductions in average family size sufficient for population stability can be achieved faster when family planning services and information are combined with appropriate development policies and programs. For as parents become more determined to have smaller

---

1/ In other words, prevalence exceeds 30%. One major example is in parts of Indonesia.

families, they naturally become more willing to use the services available, however imperfect those may still be.

In recent years, AID has devoted both Title X and other AID resources to exploring the links between fertility and development policies and programs so that all AID assistance programs -- or those of other donors or LDCs -- can be designed as appropriate with a view to their possible impact on fertility. We expect to expand such efforts in the future.1/

Developing a strategy for population-related assistance thus requires determining what sorts of family planning services and information appeal most (and what they cost), what development policies and programs encourage smaller families most (and what they cost), and how these may best be combined.

One major conclusion is that we are woefully short of hard information on which to judge services, information, or policies -- because services and information are not widely enough available to permit measuring their ultimate impact accurately, because measuring anything is difficult in many LDC's, and because sorting out the tangled influences on fertility -- services, information, and all the other changes development brings -- is difficult even with sophisticated statistical analytic techniques.2/ That sort of analysis certainly cannot get far with the data now available. Major attention needs to go into developing and refining the

1/ The trade-offs among different types of Title X expenditures will be discussed briefly in the conclusions section.

2/ Multi-variate analysis of fertility determinants requires data sufficient to permit reasonable separation of the impact of a given influence from that of everything else.

necessary data and techniques. Only thus can we sort out just which approaches are likely to reduce birth rates fastest and at lowest cost and what the trade-offs and complementarities among such approaches may be. Among other things the Agency should build more such analysis into its annual program review process.

Even at present, however, some reading of the comparative effectiveness of various services, information and education programs, and development policies and programs can be made.

OUTLINE OF THE ANALYSIS

We examine experience in reducing fertility through policies and programs divided into three categories: Development policies and programs; information, education, and communication efforts; and family planning services. We give particular but not exclusive attention to U.S.-assisted efforts, both bilateral and intermediary programs. Given what has worked in the past, what AID's role has been, and what new approaches seem most promising, we suggest future policy and program directions for U.S. population-related assistance for countries requesting such assistance.

We base our analysis on assessments of development policies, IEC, and family planning services in most LDCs of major U.S. interest. These are available as Annex 1 to

to interested readers. In addition, we have made special studies of ten countries of major importance to the U.S. or with particularly interesting family planning programs: Bangaldesh, Indonesia, Korea, the Philippines, and Pakistan in Asia; Ghana and Tanzania in Africa; Colombia and El Salvador in Latin America; and Tunisia in the Near East. The country studies are also available as Annex 2 to interested readers.

FAMILY PLANNING SERVICES

Methods: offering variety

In terms of methods, the most effective approach seems to be to offer variety. Each method has its own adherents. No program focusing on a single method has achieved dramatic success. But several methods -- pills, condoms, sterilization, and abortion -- seem particularly effective and appealing to users.

Pills, which are effective and easy to use, appeal particularly to the young, to those with few or no children, to those with little access to clinics, and to those who want to space births. Many family planning programs began before pills were widely available, and enjoyed sharp increases in acceptor rates when pills were introduced.

Not all pills have the same chemical composition, and some are less likely to produce side-effects like nausea. Choosing one of the pills less likely to cause side effects and maintaining a supply of the same pill can be crucial to continued use.1/

1/ Thus AID is supporting research to explore side effects and thus help provide more suitable pills to clients.

The appeal of condoms is less well documented, but given their low cost, ease of distribution, effectiveness, and absence of side-effects, they deserve further attention.

Sterilization -- both vasectomy and tubal ligation -- has proved surprisingly appealing even among poor, ill-educated people with no more than three children; it is an obviously effective method, can be handled on an outpatient basis fairly inexpensively, and deserves to be encouraged considerably.

IUD's have proved acceptable, but particularly in better-off LDCs like Taiwan and Korea where medical follow-up is good and where side-effects did not cause undue medical problems or cultural backlash.1/

Foam and diaphragms have their adherents but do not appeal to many people and are relatively difficult to use effectively. They should be considered, but probably not encouraged.

Available data indicate that safe, legal abortion finds ready acceptance in many countries, even where good contraceptives are widely available. AID is barred by the Helms Amendment from financing abortion.

In terms of AID's own assistance to family planning service programs, perhaps pills, condoms, and sterilization stand out as deserving priority over the next several years.

1/ In some countries, the extra bleeding sometimes caused by IUD's is regarded as unclean, and the woman is not allowed to cook for her family.

Acceptance rises when methods improve, and the methods we have are imperfect. Ideally family planning should be so easy and inexpensive that no couple would think of doing without it unless they truly want a child. Thus, research is particularly needed to explore possible side effects of pills and other methods to achieve reversible sterilization, and to develop longer-acting contraceptives, including injectibles.

Modes of delivery: village distribution

In terms of delivery systems, village-level distribution[1/] (incorporating village-level leadership) deserves major focus at the moment. The fastest growing and most vigorous programs seem to be moving in the direction of non-clinical and non-commercial distribution of services in villages. Early results are encouraging; acceptor rates exceed 30% of fertile-age couples in some areas.[2/]

Most family planning programs have begun in clinics, and most are still clinic-based. For countries able to afford to put clinics within easy reach of all people, extending the clinic system may be the best way to improve family planning services. In some areas (particularly in Latin America) where clinics are already fairly plentiful,

---

1/ House-to-house or at least with services accessible within the villages.

2/ Notably in rural Indonesia and Egyptian pilot programs. In Indonesia, strong peer pressure is a key point of the program.

additional family planning services should certainly be integrated into clinics or expanded to assure they are available daily. In some areas we may have no choice but to limit programs to clinics, though there may be a better way than exclusively clinic-based (or clinic-bound) services.

Few developing countries can really afford the clinic route; most now serve only 15-20% of their populations with clinics. To reach the poor majority and keep total program costs manageable, most countries must limit per-user costs by paring services down to bare essentials. This means trying to serve areas beyond easy reach of clinics with paramedics or "health auxiliaries" -- midwives, "promotoras" and other low-level and possibly multi-purpose workers -- instead of physicians.

Pilot level experience indicates that health auxiliaries or even village people with a little training can be used effectively to provide excellent family planning information and services. They can distribute contraceptive pills (though easing prescription requirements is a prerequisite), and auxiliaries can insert IUDs (even in the U.S.!). Some do sterilizations safely if well trained and supervised, though AID so far has preferred physicans in the performance of sterilizations.[1/]

(See page 13a for footnote.)

1/ It bears emphasizing that consumer safety arguments actually militate in favor of a judicious easing of prescription requirements and restricitions on health auxiliaries. Present evidence indicates strongly that the hazards to poor, undernourished women of repeated pregnancy and childbirth in the absence of a physician are far greater than any hazards, which appear to be minimal, from contraception in the absence of a physician particularly when good paramedic supervision can be provided. Maternal mortality rates in many poor LDCs approach 500 per hundred thousand (as compared to about 20 in the U.S.). Mortality from complications of oral contraceptives (mostly thromboembolic) in developed countries is on the order of 3 per hundred thousand per year (bearing in mind that three year's use averts one birth on the average), increasing several-fold for women over forty who of course also suffer higher maternal mortality. But women in LDCs have fewer thromboembolic complications from oral contraceptives because their different diets, work habits, exercise levels, genetic background, etc. leave them far less prone to blood clots. Of course some people may be reluctant to assume the risks of a "new" method however they compare to the long-endured risks of pregnancy, just as people are sometimes hesitant to try new medicines or indeed any innovation, however promising. And to the extent pills substitute for traditional methods like abstention or withdrawal, they entail an added risk; to the extent they substitute for methods like illegal abortion, they probably entail lower risks.

While the ideal may be a doctor in every village, that cannot be achieved easily even in developed countries. Well-trained paramedics are an excellent solution and should be used far more where otherwise many people (rich or poor) will simply do without services.

Indeed, a village worker may be more effective in dealing with her peers on a personal subject like family planning than white-coated health technicians or doctors -- who are too often disdainful of their poor and illiterate clients. Much more needs to be done to expand the use of village laymen and health auxiliaries, particularly women. Private traditional or modern providers of health or family planning services -- midwives, pharmacists, herbalists -- can also be encouraged and equipped to provide a broader range of modern family planning services. Often, indeed, they already enjoy the confidence of clients, which facilitates acceptance of new family planning services.

In terms of program development, where services have begun in clinics, one generally reasonable course of action may be to gradually move pill and condom distribution to the village level and reserve clinics for more complicated services such as sterilization, IUD insertion, etc., or initial introduction to pills. In Indonesia, for example, a woman goes to the clinic for initial supplies and screening (but is served by a paramedic, not a physician) and returns

to village distribution points for re-supply. But for poorer countries, a key question is whether village-based distribution of just the simplest and most basic services can precede major clinic-based distribution, or whether a substantial clinic network must be in place to provide reasonable back-up.[1/] In poorer countries, focusing on village-level distribution before many clinics are in place may make sense, but pilot projects and research should be undertaken before ambitious national programs are launched.

Reaching the poor while keeping costs low may also call for combining delivery systems where possible, so that related health, nutrition, and family planning services can be delivered as a package. Such integration of services permits taking advantage of joint products, program synergisms, and scale economies -- getting more done for the same cost. As with family planning services only, integrated basic health, nutrition, family planning information and services can be provided effectively by health auxiliaries or trained laymen to help keep costs down. Integration at a higher level of planning and implementation for all programs with major impact on health and fertility may also be essential to get the most out of a limited budget.

Consumers may also prefer integrated services. People may more readily accept family planning services as part of

---

1/ This question is being explored in Tunisia among other places.

a broader health package because the combined services protect their privacy, because they have learned to trust health workers, because they find it cheaper and easier to get health, nutrition, and family planning services on the same trip (which may be long, expensive, and difficult), or because they want to assure the health of their existing children before foregoing additional births.

As with family planning, most rural health services have been provided through clinics. Indeed, such family planning services as are available are usually provided through those clinics, so that integration at this level has occurred. But often it has occurred imperfectly; clinic staff tend to focus on family planning one day, sick babies the next, etc. necessitating multiple trips that seriously discourage use of services.

AID is, of course, promoting integration of services wherever that makes sense. The Agency urges more complete integration at the planning level so that more programs can be brought to bear on health, nutrition, and fertility in an organized way, at a village level so that consumers have greater access to non-clinical services; and at the clinic level so that services of various sorts can be obtained daily.

In some situations it may be possible or sensible for political, economic, administrative, or other reasons to move ahead on either the health, nutrition, or the family planning front

first. That should be done; the second service can then be grafted onto the first. There is no good reason to hold back on one service until both can be implemented simultaneously. Particulary in Africa, it may be essential to provide both health, nutrition, and family planning services in an integrated way.

Of course, no family planning services will be effective without adequate administrative capacity -- procuring the necessary commodities, distributing them to assure continued re-supply, training and locating personnel, and so on. Because LDCs are often critically short of administrators, relying on local leadership (particularly for village-level distribution) can pay off very well. And intermediaries like IPPF can play a major role in reaching really large numbers of people, sometimes by piggy-backing their family planning services on publicly financed health services, sometimes by providing free-standing family planning services. But whether services are provided by government or private agencies, some central direction is crucial. Among government programs, it seems to matter less which ministry controls the family planning services than that the controlling ministry be able to coordinate effectively with others whose programs also affect services and their appeal. Giving family planning responsibility to a minister rather than a lower level bureaucrat naturally helps assure leadership.

It is worth pointing out that in some cases where governments may be reluctant to give de jure backing to family planning, de facto backing can go a long way if sustained and practical. Such informal arrangements may affect provision of all contraceptives, pill prescription requirements, etc.

At current program levels, most country analysts seem to consider present bilateral funding and supplies adequate for now, given current program scale and problems, but program planning and administration inadequate. In terms of AID programs, helping train additional family planning personnel, particularly program planners and administrators, may therefore be crucial. While funding may well become a more serious constraint as programs expand, administration is the greater bottleneck now. Interregional program funding is, however, inadequate in AID's view at present. And of course this does not suggest that services are on an optimal scale at current program levels.

The comparative cost of alternative approaches to family planning services is extremely difficult to estimate from present sketchy data. Available sources disagree, sometimes by more than 100%, on total family planning program costs for a given year. AID and other donor inputs can usually be pinpointed, but LDC inputs are more difficult to fix because health, family planning, and other expenditures are often lumped together in government accounts.[1/] Nor are data from small pilot projects or intermediary operations much better.[2/] Far more attention should go to cost data

1/ The two major sources used here are Population Council and the AID/IGA worksheet; the latter are relied on here, and generally give higher estimates.

2/ It is difficult to draw conclusions from either Danfa or Narangwal, for example; the Danfa study also has relatively little detailed data.

to assure better estimates of comparative cost-effectiveness in the future.

At present our best guess is that annual expenditures on family planning of at least $.10 per capita of total population are necessary, though certainly not sufficient, to have a meaningful program. Good programs seem to run in the $.10-.25 range by and large, though some of these are more efficient than others or are in different program stages.1/ Only a few have expenditures exceeding $.50 per capita; these include both mature and start-up programs2/ whose effectiveness varies widely.

Reported costs per new acceptor seem to run around $10-15 in most good programs.3/ 4/ Of course some new acceptors drop out; continuation rates vary. Taking into account (a) continuation rates and (b) the usual assumption that one birth is averted for every three years' protection against pregnancy, the cost per birth averted will naturally be far higher -- perhaps $50-100.5/ 6/

1/ These countries include Korea, Taiwan, Thailand, Indonesia, India, Ghana, and Nepal -- a wide variety of programs. Of course, these are only the official financial costs reported; volunteer labor, etc. would have to be included to give real resource costs.

2/ Costa Rica (impressive mature program); Tunisia (disappointing mature program); and Pakistan (ambitious new program).

3/ These are not true marginal costs; they include all program costs for old and new acceptors and may not count new acceptors accurately either. But probably they exceed true marginal cost.

4/ The $.10-.25 per capita expenditure implies a broad range of $2.50-$15 per acceptor, depending on prevalence of 10-20%. But see note 3/.

5/ Sterilization and abortion do not have continuation rate problems, and each abortion prevents one birth.

6/ These rough estimates are based largely on Asian data.

As a program matures, we expect the cost curves associated with each major program approach to look "U-shaped". Per-acceptor costs will be high in the beginning because of high start-up or "fixed" costs; they will drop as the program matures and reaches many acceptors; and they will rise again as ready acceptors become scarcer.1/ Hence, combining many approaches will help ward off diminishing returns to any one approach.

We believe that normally lower costs can be achieved through village distribution2/ and through piggybacking family planning services on available distribution systems including public clinics, private clinics, private commercial channels, and cooperative systems. We should try to avoid spending population funds on bricks and mortar or on services other than family planning, though such expenditures might be perfectly justified for non-population programs. Where family planning and other services are integrated, however, we would normally favor cost-sharing according to program shares, as determined from some reasonable if necessarily approximate analysis

But per capita program costs are not the only consideration in allocating AID population funds. One of AID's principal purposes has been to help get family planning started in

---

1/ There is a constantly changing flow of acceptors as time goes on. Exactly how this affects cost patterns will depend on differences in the characteristics of acceptors.

2/ The cost-data from the previous page is based largely on clinic-based family planning services. But village-based distribution may have resource costs far in excess of official financial costs because so many volunteers may be involved, etc.

countries where such services are very limited. This has required AID to bear a fairly high share of total program costs to get programs off the ground. Such a policy can be cost-effective utlimately if it does inspire good LDC programs. It is not easy to predict success, but we try. And we must undertake some start-up risks to have any chance of eventual broad success. Of course, we take pains to avoid investing in programs that are obviously too capital-intensive -- too many buildings, too much training compared to what is required, and so on. We look to find programs promising real impact from lean services. And we pay particular attention to shifting financial responsibility to LDCs, including the responsibility for funding contraceptive purchases or production. Given the paucity of data on which to judge comparative cost-effectiveness of alternative approaches to family planning services, the Agency is undertaking major experiments to test and evaluate alternatives under different conditions.

INFORMATION, EDUCATION, AND COMMUNICATION

Educating and informing potential acceptors on the benefits and requirements of family planning seems essential; various IEC efforts have apparently helped encourage the use of family planning services.[1/] But considerable debate exists over which approaches work best. Data on IEC are extremely sketchy; we do not yet have a precise sense for the proper role of IEC or for IEC funding requirements particularly vis-a-vis services. More attention must be directed to assessing comparative cost-effectiveness of different IEC approaches,

1/ Whether these are most appropriately funded locally or from foreign exchange provided by aid donors is another question.

and more approaches should be pre-tested.[1/]

Past IEC efforts span a broad range -- interpersonal contact, meetings, TV, radio, posters, pamphlets, puppet shows, traditional theater, etc. Many have been mass media campaigns designed to spread a general awareness of family planning among present and future generations. The limited evidence now available suggests IEC efforts work best when they are country-specific, when they advertise specific family planning services, when they "make a case" for family planning in personal health, economic, or other terms,[2/] when they involve short, self-contained messages, when they reach many people at once, when they use a variety of approaches, and when they use low-cost media requiring little or no reading. For AID, use of radio and "comic book" materials in preference to higher cost TV and films may be indicated, though radio, TV's, and films can all have major outreach into village life. Any opportunities to "piggyback" a family planning message in existing publications, programs, etc. should naturally be seized. The simultaneous use of multiple channels and media may be crucial to encouraging acceptance particularly as time goes on. Of course, peer pressure can be the most persuasive form of communication, and should be considered.

1/ Determining cost-effectivness of alternative IEC approaches is extremely difficult, of course, because of the problems of relating subsequent changes in behaviour to IEC as opposed to other intervening influences like new services.

2/ Arguments in terms of national benefits seem less persuasive generally, though there are cases where they seem to have effect.

If the key to extending family planning services in rural areas is simple and inexpensive information and a few goods supplied through health auxiliaries or laymen, then the role of the IEC message becomes critical. The key to success in such programs will be the ability of the health/family planning worker or volunteer to lead his or her neighbors to do something differently. Much AID attention could usefully be directed to this interface between worker and villager. How can the worker best motivate on family planning? Similar problems exist at clinics, of course, where much family planning advice is provided by doctors or auxiliaries many of whom expect to be obeyed, not to motivate.

DEVELOPMENT/POPULATION POLICIES AND PROGRAMS

It is a common observation that family size falls as modernization proceeds; in the more advanced countries, family size began to fall even before good family planning services were widely available. As parents become more determined to have smaller families, they will be more willing to use available family planning services despite their imperfections. And when education, health, or other non-family planning budgets can also be brought to bear on fertility, the family planning budget will be that much more effective. Thus it is important to ask what about the development process most influences parents to seek smaller families, and how smaller families may be encouraged.

Answering this question requires unraveling a paradox: for a nation as a whole, when population grows significantly faster than supplies of other productive resources, the eventual result must be low labor productivity, hence low living standards, unless technical change continually intervenes to save the day; yet in populous countries many poor parents (particularly in rural areas) still insist it is in their interests to have three or more children. Why? The answers are complex, but some useful insights are emerging.1/

Odd as it may seem, even for the extremely poor -- the landless rural laborer or very small-scale farmer -- the pittance each additional child earns probably exceeds the additional cost of supporting that child, for parents provide little more than minimal extra food.2/ Crucial to this analysis is the parents' belief, probably well-founded, that their children cannot break out of their current poverty to anything qualitatively different -- that substantial education, land acquisition, better health, and other means to a really better life are simply not realistic possibilities. The additional cost of another

---

1/ Certainly more research should be done.
2/ Dowries, bride-price, and a few other costs may also concern poor rural parents.

child is kept low in good part because of this ceiling on parental expectations.[1/] For such parents, the only road to whatever modest improvements they can achieve lies in increasing family income through the contribution of several children. Moreover, since such parents must usually rely on their children for old-age support (there being no institutional form of social security), they need an ample supply of children, particularly sons. With high child mortality, they may well "over-insure" to prevent disaster. These high family-size preferences get codified into social customs; most women get their satisfaction and status from having large families. Aspects of this description may be debatable in different countries, but the gist of it emerges again and again from analysis of poor rural areas.

All this suggests parents may opt for <u>far fewer children</u> -- say just two -- only when they have a quantum improvement in living standards that encourages them to prefer fewer children of higher quality (in terms of health, education, earning power, etc.) to many hungry, illiterate ones who can earn but little. The key is to make the fewer-

---

1/ If population growth persists, labor producivity may decline until it equals the marginal cost of another child--at subsistence wages or the equivalent. But the basic purpose of development is to raise the marginal product of labor, especially among the poor. This may or may not be consistent with maximizing GNP growth. It is possible that allocating investment capital to both human capital and, say, physical capital in agriculture would raise individual living standards of the poor faster than allocating it all to agriculture, if the latter allocation would lead to faster GNP growth but had less impact on fertility.

but-better option be real--and seem real--to poorer parents.

There is ample reason to believe that massive rural development with major production increases directly benefiting the poor, accompanied by education, health, nutrition, and family planning services and supported by active community organizations, encourages declines in fertility, especially as women are encouraged to move beyond their traditional roles. A few LDC's, especially those enjoying sustained and substantial GNP growth, can afford this route and show encouraging progress. But what about the others? They must be far more selective, finding the pressure points of the development process that most encourage lower fertility and focusing on those. Of course, the better-off LDCs working to lower fertility will also find the job that much less costly if they too focus on these pressure points.1/

What are these pressure points? They seem to fall in five major areas. One is public leadership, laws and administrative regulations, which can encourage smaller families at very little cost. High-level statements favoring small families and opinion-leaders' visible support for family planning can help. Other apparently effective measures include raising the minimum legal age of marriage, relaxing restrictions on abortion,2/ easing prescription requirements

1/ This does not suggest that LDC's focus exclusively on programs that encourage lower fertility, of course.

2/ There is no doubt that liberalization of abortion has helped reduce birthrates even in countries with good contraceptive services. The Helms Amendment restricts AID's activities on abortion.

on contraceptive pills, and permitting paramedics to provide a broad range of family planning services. Other possibilities include restricting child labor, passing right-to-work laws for women, providing opportunities for working mothers to breastfeed, and restricting subdivision of agricultural land, though these all entail obvious problems.

Another key pressure point seems to be the status of women.

Female education, even if pursued for only four to six years, seems to encourage significantly lower fertility. The more extended the education, the fewer children the woman is likely to prefer. But exactly how or why female education encourages lower fertility is not entirely clear, and should be explored further. Preferences for smaller families seem to result from work activities outside the home, from middle-class family aspirations shared with an educated husband, and -- apparently particularly important for women with only a few years' education -- from an introduction, however fleeting, to the notion that women need not live today, even in poor countries, quite as they always have.[1/] Where education affects fertility primarily by equipping women to work outside the home, the availability of jobs as well as education becomes important; but aside from employment opportunities, education alone seems to encourage lower fertility in many areas. Where budget limitations prevent attaining even a few years' education, this approach to reducing fertility may be limited.

1/Some changes may be pro-natalist, of course. We need to sort out better the sorts of changes that most encourage lower fertility.

Female employment, particularly in jobs incompatible with continual child-bearing, is also strongly tied to fertility declines. We do not know what the fertility impact would be if poor women were given access to more-than-menial jobs, but sketchy evidence suggests that they might indeed opt for fewer but healthier and better educated children as their expectations and opportunities for themselves and their children rise. In countries suffering substantial and chronic male unemployment and underemployment, of course, it may be argued that more good job opportunities for women must be put off for another day. It is particularly important, therefore, that care be taken with employment opportunities for women, that jobs do not simply continue the exploitation of women which is all too common particularly among the poor and that children are cared for, especially among the poor.

Also promising are any measures like women's associations for health, handicrafts, etc. that help replace the fatalism of the traditional woman with a sense that one can improve one's own life at least to a degree.

A third pressure point involves changing the economic cost and benefits of children to encourage smaller families through the deliberate use of rewards (incentives) to parents who limit fertility or penalties (disincentives) on parents

who do not.[1/] In considering incentives it should be remembered that social and economic conditions inevitably influence parental views on family size - or on health, savings, employment, etc. Incentives are but one way of deliberately adjusting economic conditions to encourage smaller families; the alternative to deliberate action is, of course, laissez-faire with all that implies for haphazard influences on individuals. Incentives do, of course, leave parents who truly want many children able to choose large families.

It bears emphasizing that when population pressure on resources is extreme enough so that labor productivity is very low, then averting a birth can save resources; an incentive can be designed to give part of this saving to those who made it possible--the couple practicing family planning. In other words, when demographic pressure exacerbates resource scarcities so that some rationing of some goods outside the market is virtually inevitable, then one reasonable basis (or practical basis) for that rationing is to favor those who help ease demographic pressure. When parents rely on children for old-age support in the absence of social security, providing extra resources as an incentive or reward for family planning can compensate for what additional children might have provided to their

---

1/ Incentives at least preserve freedom of choice, and can be designed to fill real economic needs of parents at little or no social cost.

parents, and so fill a real economic need of parents at little or no real cost to society. (In the shorter run, of course, there may be budgetary problems in managing incentives.)

A fourth pressure point is child health, as discussed above. As more children survive, completed family size will supposedly fall.1/ To the extent this argument is valid, it militates in favor of integrating health and family planning services or at least seeing that both are provided in a coordinated way.

The fifth and perhaps most important over-arching pressure point is broad rural development. Cross-country studies suggest countries with more egalitarian income distribution have lower fertility, but no one is quite sure why. Studies of poor countries over time (as income distribution changes) are lacking. In these countries, it appears that income growth alone need not lead to lower fertility at any time soon, at least if the increases are modest and bring income to no more than low-to-moderate levels; it all depends on how the income growth comes about. As we said at the start of this section, massive rural development involving sustained increases in agricultural production (particularly food), infrastructure, health services, and education, supported by active community-based organizations, can encourage lower fertility if it involves and benefits the majority who are poor and if

---

1/ The evidence on this point is sketchy. Considerable additional research is needed to determine whether parents are over-insuring, what it would take to get them to stop, etc.

it encourages new options for women.[1] But because of budget limitations, relatively few LDCs can afford such widespread and massive rural development; most must take a more selective approach to reducing fertility and stimulating development, focusing on those aspects of rural development that promise both increased output and smaller families in order to raise individual living standards as much as possible given available budgets.[2] Generally the aspects of rural development that most encourage lower fertility are the same as in development as a whole--the aspects we have just discussed in points one through four.[3] Thus the wheel comes full circle.

Given its Congressional mandate, which of the fertility-reducing policies and programs should AID encourage particularly through its programs?

AID's Congressional mandate includes among its several objectives the voluntary reduction of fertility through both provision of services and policies to strengthen motivation for family planning; reducing fertility can be crucial to efforts to improve per capita living standards, which is the ultimate objective of our mandate and indeed of most LDCs. Thus the question is whether working to lower fertility through changes in development policies and programs will seriously compromise

---

(See page 31a for footnotes.)

Footnotes for page 31.

1/ Many people believe the poor must reach a new threshold of well-being (especially in terms of food) before they will seek families of about two children.

2/ Assuming reducing fertility is an objective of the LDC concerned.

3/ One must ask whether this suggests investing in health, education, family planning "instead of" agriculture. Of course the decision must be the LDC's. But the evidence suggests it may be preferable to combine investments in agriculture with modest investments in these other fields to get both growth and lower fertility, hence fastest improvement in per capita living standards. If all productive resources were owned by all people in equal shares and if each factor earned its efficient economic return, the maximum improvement in per capita living standards would occur when output growth was maximized--in whatever factor intensities that resource endowments and technology indicated were optimal. But particularly if poor people have only limited claim on productive resources other than their own labor, raising their living standards requires raising their labor productivity--technically, the marginal product of labor. This in turn depends not only on how fast output grows, but also on how slowly population (hence labor force) grows and how labor quality changes. All things being equal, the more output, the higher the MPL (Marginal Product of Labor); the fewer the people, the higher the MPL. With most LDC economies grounded in agriculture, agricultural output is certainly the cornerstone of poverty-focused development. Investing to augment capital supplies and improve technology in agriculture may maximize the growth of agricultural output, thus raising the marginal product of labor. But it may not in and of itself help dampen fertility. A more composite investment package focusing on human as well as physical capital may help more to stimulate output and dampen fertility. More precisely, investing a little less in agricultural capital and technology and a little more in family planning, other health services, basic education especially for women, etc., may provide almost as much stimulus to agriculture, hence output growth, while also encouraging smaller families--thus possibly working more effectively to improve individual living standards.

other mandate objectives or violate mandate restrictions in the attempt to improve per capita living standards for the poor, particularly in rural areas.

Basically, the policy changes needed to lower fertility are the same ones needed to reach other mandate objectives. While some qualification is necessary, generally the more AID assistance serves to improve the well-being of the poor (especially women) and involve them in development processes--whether through rural development, improved food production and more equitable distribution, widespread and practical education, broad and effective health programs,1/ programs that combat malnutrition, measures that help foster reasonable trust in political and economic institutions, or programs that generally encourage and equip people better to take charge of their own lives--then the more AID's assistance also serves to contain fertility.

Thus the basic recommendation here is for more coordinated programming, not only to reduce fertility where that is desired but also to take other steps toward the ultimate goal of improving the life of the poor. The principal focus of AID efforts will be on rural areas, both because most poor

---

1/ Including child-spacing.

people are in rural areas and because improving conditions in rural areas will make it that much easier to combat urban problems (most of which are exacerbated by migration from rural areas of people who find too little there to persuade them to stay).

In most AID developing program categories, like education, agriculture, etc., of course, not all programs can serve equally well both their own primary purposes and the secondary purpose of reducing fertility. So far AID has stressed maximum fulfillment of primary purposes. But without jeopardizing the primary purpose of a given program, we may be able to gain a secondary but significant impact on fertility through reasonable and feasible changes in program design and implementation.1/ It should be borne in mind, however, that careful assessment of all the benefits and costs of alternative programs should govern AID funding decisions. While fertility benefits may be important, they must be considered alongside other benefits and within the context of resource availabilities, management capacity, etc. Specific suggestions follow; more need to be developed.

1/ As such dual-purpose programs expand, a serious trade-off may develop between the best primary-purpose programs and the dual purpose ones, but that bridge can be crossed when and if we come to it. For now, suffice to emphasize that lowering fertility and meeting the mandate's other objectives through development policies will in many cases involve complementary, not competitive efforts. Recent experience involving agricultural extension workers and volunteers in teaching family planning may be one example.

1. Food and Nutrition; Rural Development

a. Programs to promote growth in and more egalitarian distribution of income and public benefits, goods, and services.

AID's mandate recommends increasesin and more egalitarian distribution of income, goods, and services for non-population reasons.[1/] AID programs should therefore provide ample opportunity for research identifying links between distribution and fertility, and for programs better exploiting those links as they become clearer.

b. Food production and distribution.

AID or PL 480 programs designed to stimulate food production and assure its more equitable distribution can affect fertility in several ways--as an addition to income, as means of lowering food prices to make available income go further, as an improvement to health through better diets, and as food production depends on female or child labor.

AID is taking major steps to enhance the development impact of PL 480 both Title I and Title II, particularly in the areas of food production and population planning consistent with LDC preferences. AID or PL 480 programs designed to stimulate food production and assure its more equitable distribution can affect fertility positively or

(See page 34a for footnote.)

negatively in several ways--as an addition to income and employment (and a curb to urban migration), as a means of lowering food prices to make available income go further, as an improvement to health through better diets, and as a means to lessen the involvement in food production of traditional child labor. Provision of PL 480 Title II may be used through Food-For-Work or other programs to support establishment

1/ This is a broad-based concept including such matters as agricultural credit, provision of inputs, rural electrification, etc. which may in fact have a strong impact on fertility. In the Philippines in one area where rural electrification has been carried out, birth rates are sharply down in comparison with a similar area without electrification. Increased access to desirable consumer goods (irons, stoves) and increased employment opportunities especially for women (who now do housework at night) seem to be part of the story, resulting no doubt not just from electrification but also from other development policies increasing the demand for labor, etc.

of such things as schools, health outposts providing health, nutrition, family planning services, etc. AID plans to give major attention to the linkages between PL 480 and aspects of the development process including population planning.

c. Employment

AID programs focusing on employment creation should consider both men and women, particularly among the poor, not only in order to fulfill the purposes of the mandate as expressed in the Percy Amendment but also for fertility reduction purposes. Attention should go to the need for child-care that inhibits employment in non-traditional occupations for many mothers especially poor ones. Food processing and marketing of agricultural products may offer special opportunities for women.

d. Education within rural development programs

AID's rural development programs should consider increasing emphasis on women as well as in education provided through agricultural extension or other program components. Moreover, opportunities should be seized to integrate population and family planning messages in agricultural or other rural programs in ways meaningful to the poor who are supposed to benefit.1/

e. Nutrition within rural development programs

As noted above, AID programs in health, nutrition, and family planning can be mutually reinforcing. Agricultural

1/ Studies have demonstrated a coorelation between reduction of fertility and some level of primary education. But the required level of education varies among countries and will be examined further.

and broader rural development programs reaching the poor can play a major role in improving nutrition, hence health, by increasing the food supplies that will provide both home consumption and income needed to improve diets and by incorporating information on health and nutrition (e.g. better lactation and weaning practices) or feeding programs into other rural development programs.

f. Community Organizations

The encouragement and improvement of administration and organization at the village level have a number of primary and secondary effects on fertility. Village cooperatives can provide an organization for increasing agricultural productivity and marketing capabilities. (They can also become an interest group for land reform, if that is a needed structural change for agricultural development.) Local government organization can foster individual participation in community decisions and increase awareness of individual responsibility to the community. It can serve as a vital link between villagers and higher levels of government. And it can become a mechanism for mobilizing support for community infrastructure projects and for improving social services. Specifically related to family planning, local government

can act as focal point for entry of an integrated health, nutrition, and family planning program or a single-purpose family planning program into a community. Through education interest groups it can improve local education opportunities for the whole community and women in particular. Through "wives'" and "mothers" clubs and other women's organizations local government can develop a peer-pressure group for creating demand for family planning services, and a distribution system for supplying family planning services, and a feedbac mechanism for determining family planning success or failure at the family level, as well as a useful local adjunct to the national census system. Moreover community organizations can assist in the training of administrative and managerial talent and can directly tie economic and social development (and family planning in particular) to the village, the level of government closest to and most involved and interested in the individual.

g. Incentives

Some LDCs may be interested in organizing individual incentive programs with AID technical and financial assistance, drawing on past experience with education bonds, savings accounts, and the like. (Certainly savings institutions including cooperatives should generally be encouraged.) Community incentives--rewarding a community's efforts at family planning with additional health, education, or other

services--can also be explored in interested LDCs. Some LDCs, especially in Asia, have expressed interest in or tried such initiatives. (See point b.) Other changes -- increased demand for labor, increased access to consumer goods provided through improved roads, rural electrification, etc. -- can provide more several but powerful incentives for smaller families.

h. Women's status

Many of the measures discussed in a.-f. have the effect of increasing opportunities for women, encouraging a sense of being able to control and change one's own life at least to a degree, and thus seem likely to encourage lower fertility. Any other aspects of rural development with similar impact on women are likely also to encourage lower fertility, and thus merit AID consideration for both fertility and status-of-women purposes. More women's associations dealing jointly with family planning (see above), education, maternal/child health, handicrafts for market, etc., may be particularly effective.

2. Health and Population Programs

As Part 1 of this paper emphasizes, health, nutrition, and family planning programs can be mutually reinforcing; integration of basic, low cost health, nutrition, and family planning services is specifically recommended in AID's legislation. Thus AID is encouraging development of low-cost integrated health, nutrition, and family planning services for the majority where integration makes sense. The design of such delivery systems is an essential principle of the health program. Thus AID is supporting all sensible types of service integration--

organizational integration at clinic and household

levels and integrated planning. Perhaps the greatest gains in health and family planning can be made jointly through greater integration at the household level, to emphasize especially to women the interrelationships between health, nutrition, and family planning and to encourage them to put more of their own efforts into health and fertility management, thus making public funds go further.

Integrated planning of all programs affecting health should also be encouraged, of course, to assure maximum impact on health, hence fertility, of those programs acting jointly. This will assure appropriate weighing of the likely health and fertility impact of single-purpose programs like malaria eradication or free-standing family planning services or commercial sales of contraceptives as well as the organizationally integrated services.

3. Education

AID seeks to avoid discrimination against both women and men. But, in many LDCs far more boys receive rudimentary education than girls (the ratio is 4 or 5 to 1 in many areas), to say nothing of higher education. The knowledge that educating girls even a few years may help lower fertility can encourage further action to integrate women into the development process as suggested both in AID's legislation

and in the plan of action deriving from the International Women's Year Conference. In short, lowering fertility and integrating women more fully into educational processes go hand-in-hand, though, of course, other benefits of education must be given their weight. As to content of education programs, it stands to reason that information on family planning and family health, alternative roles and income-earning opportunities for women, and the possibilities for managing one's own life generally help to encourage smaller families. AID can encourage modifying educational content to include more on such subjects.

CONCLUSIONS: DIRECTIONS AND POSSIBLE FUNDING LEVELS FOR U.S. POPULATION-RELATED ASSISTANCE

The analysis presented so far suggests program directions and, though far more tentatively, possible funding levels for U.S. population assistance including (a) Title X population assistance and (b) other AID assistance and PL 480 that may indirectly but significantly affect fertility. Since the primary purpose of Title X assistance is to encourage voluntary reduction in fertility, funding decisions should be based on a careful assessment of the cost-effectiveness of alternative, appropriate approaches to reducing fertility. On the basis of current information, AID intends to use Title X population assistance largely to improve and extend better family planning services, to fund population-based components of integrated programs (e.g. family planning messages in education programs or family planning services in integrated health, nutrition, and family planning services) or to fund other measures with the primary purpose of encouraging small families.

Generally, other monies will be used to fund programs in education, health, nutrition, rural development, etc., whose primary objectives do not include fertility reduction but which may have a major secondary effect on fertility. It is expected

that due weight will be given to any secondary impact on fertility when the benefits and costs of alternative programs in these other areas are considered, though final funding decisions will of course depend on all the benefits and costs. (Program planners in such areas should also consider research on links with fertility.)

To explain how the new program directions suggested here and the funding levels outlined here relate to present Title X population assistance, we outline briefly the organizational structure of that assistance.

Current AID Title X Population Assistance

AID's population program, since its beginning in 1965, has become the world's foremost source of such assistance and a major source of ideas on fertility control. In the past ten years, AID has provided about $750 million in population assistance with annual amounts increasing to the current level of $110 million. At present this assistance is organized into six functional categories:

Category 1:	Demographic data	(to help assess demographic trends)
Category 2:	Population Policy	(to identify the national self-interests that justify population growth limitation policies and to identify development policies/programs that encourage fertility decline.)

Category 3: Research (to help develop better methods of family planning and more efficient delivery systems)*

Category 4: Family Planning Services (to help extend safe, effective, and affordable family planning services especially to the poor)

Category 5: Information, Education, and Communication (to help extend family planning information especially to the poor)

Category 6: Manpower and Institutional Development (to help develop adequate manpower and institutional capacity in family planning)

To countries wishing to reduce fertility AID extends assistance through bilateral programs, through programs funded by donor consortia, through official multilateral institutions like the U.N., and through intermediaries like IPPF and Pathfinder; assistance is implemented in a collaborative style with the LDC's concerned.

TITLE X POPULATION ASSISTANCE: DIRECTIONS AND FUNDING LEVELS

As a next step we outline potential program directions within the six functional categories. We assume somewhat higher annual program levels, perhaps around $200 million for the next few coming years, and indicate a) relative declines in funding levels; b) stable or continuing levels; c) moderate increases (0-50%) and sharp increases (over 50%) all in real terms.

*Subject to any legislative restrictions (e.g. Helms amendment).

Program Directions

Category 1: Demographic Data

-- Since many countries now have some sort of at least superficial national censuses, we expect to have stable or declining funding for national censuses in the near future except where needed to establish censuses or where techniques for developing more detailed data (see below) may be applicable nation-wide.

-- Moderately expand efforts at developing more complete and detailed demographic data nationally or at least for some representative samples among the poor to permit more accurate estimates of the demographic impact of various family planning services, information activities, and development programs.

Category 2: Population Policy

-- Moderately expand LDC-based research on the policy variables that reflect linkages between fertility and various aspects of development, including:

a) female education of various types and levels;

b) female employment;

c) health (especially of children);

d) nutritional status of women and children;

e) incentives/disincentives to encourage smaller families;

f) income growth, distribution, and rural development (focusing specifically on food);

g) laws and policy statement supporting family planning.

-- Moderately expand "population impact" analysis and other measures to encourage broader understanding of the development implications of population growth and the potential for bringing development programs to bear on fertility;

-- Moderately expand pilot experiments in a)-f).

Category 3: Research

a) Bio-medical Research *

-- Moderately expand projects to field-test promising new family planning methods;

-- Moderately expand research to develop new methods (particularly once-monthly methods and better and more reversible methods of male and female sterilization) and research on side effects of available methods, particularly pills.

-- Moderately expand research on the relationship between nutritional status and fertility.

b) Operations Research

-- Sharply expand LDC-based research on the comparative effectiveness of alternative approaches to family planning services and information, focusing particularly on basic, low-cost village-based distribution with short start-up times.

-- Sharply expand LDC-based research on what services health auxiliaries and laymen may be able to provide.

-- Sharply expand research on whether or under what conditions village-distribution schemes using low-level health auxiliaries or lay personnel can be established without much clinic backup.

-- Moderately expand research on prospects for LDC production of contraceptives and other family planning supplies.

Category 4: Family Planning Services

We expect the major focus of Title X population assistance to continue to be on extending better family planning services; within that focus, we shall give priority to providing more low-cost services for the poor, particularly in rural areas where the vast majority still lack any but traditional services. We shall:

-- Encourage provision of a variety of family planning methods, particularly pills, condoms, and sterilization;

-- Sharply increase efforts to help establish and expand village-based distribution of family planning services in rural areas particularly through low cost systems relying on health auxiliaries and laymen and promising short start-up time

* Subject to any legislative restrictions (e.g. Helms amendment).

-- Encourage integration of health, nutrition, and family planning services wherever sensible, taking care to encourage movement on either the health or family planning front where simultaneous movement may be very difficult;

-- Seize opportunities to "piggyback" family planning services on existing delivery systems, particularly clinics, where they are available (e.g. some Latin countries);

-- Encourage allocation of health funds to the establishment of low-cost delivery systems reaching into rural areas that could add in family planning where that approach seems most promising (e.g. some African countries).

-- Encourage provision of appropriate contraceptives through commercial outlets like pharmacies or small shops or through private channels (e.g. midwives);

-- Work with intermediaries, public-funded programs, or both depending on potential effectiveness.

In terms of country priorities, we take our primary objective to be getting family planning services started in developing countries; we will, of course, give careful attention to encouraging those countries to assume total responsibility for their own programs, particularly for their major contraceptive requirements.

Category 5: Information, Education, and Communication

-- Where broad-based family-planning awareness campaigns have not been undertaken, we would encourage those; but since many countries have undertaken such campaigns, we expect relatively less emphasis in this area.

-- Where basic awareness exists, fine-tune existing IEC efforts so they are:

a) country and culture specific;

b) informative on each specific methods of family planning;

c) related to personal needs and aspirations;

d) focused considerably on the interface between village family planning worker and village client;

e) reliant on relatively inexpensive media with broad out-reach that require little reading (e.g. radio).

-- Sharply expand operational field testing and collaboration with the research of other agencies such as UNESCO and UNDP to better determine which combinations of the many modern and traditional media and methods are more efficient, effective and suited to the special and evolving needs of differing countries and family planning programs.

Category 6: Manpower and Institutional Development

-- Sharply expand efforts to help train health auxiliaries or laymen for village-based distribution.

-- Continue efforts to provide advanced training for leadership teams and supply technical assistance to in-country training institutions to man combined health delivery systems and focus on filling specific needs, e.g. for personnel equipped to provide surgical contraception.

-- Moderately expand efforts to strengthen planning and management capacity at all program levels.

-- Continue efforts to assist in-country institutional development to meet longer term support needs for training, research, information storage and retrieval, and the like.

Title X Funding Levels

With data presently available, it is possible to make a case only for very rough funding levels. We do believe, however, that Title X population assistance could easily be justified at considerably higher levels, perhaps $200 million annually in program funds for several years, to finance programs along the lines just outlined.1/

Ideally one would set a certain target reduction in birth rates and from that deduce funding requirements for various types of family planning services and information and development policies. We cannot do that with any accuracy, however (of course, we face similar problems in other program areas). Both data and methodology are inadequate at the moment to sort out all the tangled influences on birth rates with any precision, though as emphasized above, more efforts should go to improving both data and methodology. Current AID projects along these lines will help considerably.

Using available estimates of population, numbers of fertile age couples, costs of family planning services, and the relationship between prevalence of family planning and birth rates, one can make rough estimates of the annual costs of just the services needed to increase prevalence enough to reduce birth rates another 10 points -- apparently in the

---

1/ Excluding UNFPA.

$300-400 million range. But such estimates are so rough as to be of very limited value.

All this says nothing specific on appropriate levels for AID funding of services, let alone other areas of our population assistance. In the past, to get family planning well underway in many LDCs, we have found an AID expenditure for services of around $1.00 per capita total over a decade is often enough; of course this does not bring down birth rates to stable-population levels, but only to more moderate levels where services are well enough established to be taken over and expanded by the LDC concerned.[1/] But this suggests that U.S. expenditure in the neighborhood of $2.5-3.0 billion[2/] over 1965-85 could go a long way toward at least getting family planning services well established though probably not on a scale sufficient to achieve anything close to population stability. Of course additional funds would be needed to support balanced efforts in areas other than provision of services -- demographic data, information, research, manpower, population policies, etc., our recommendation of $200 million annually is based on such a total approach. The Agency, the Executive Branch, and the Congress might focus on just what the Agency's objectives in terms of fertility reduction

---

1/ These were people who already wanted services, the extent of unmet demand is subject to serious debate, of course.

2/ In 1975 dollars, roughly.

should be. Funding for population must ultimately reflect other concerns, however -- such as LDCs' interest in such assistance, absorptive capacity and the ability to use funds efficiently, the role of other donors, the role of LDCs in funding, and competing demands on U. S. funds.

OTHER AID PROGRAMS AND PL 480: DIRECTIONS AND FUNDING LEVELS

Other AID programs -- in food and nutrition (and broader rural development), in education, and in health -- can affect fertility indirectly but significantly as discussed above. It bears reiterating that basically the same types of programs in these areas will help to reduce fertility, increase aggregate supplies of key goods and services, insure their more equitable distribution, and otherwise foster wider participation in development -- in pursuit of the mandate's basic objective of improving individual well-being among the poor. Many of the measures helping most to reduce fertility also help particularly to improve the status of women.

It is particularly important to improve our broad understanding of the links between fertility and rural development, education, health/nutrition/family planning programs, etc. to permit planning, implementing, and evaluating the best possible combination of programs and projects that will act in coordination to improve welfare, ease population pressure, etc

Specific program directions are discussed below. We emphasize, however, that in each area, additional LDC-based research needs to be undertaken, financed not only by Title X but also by the programs concerned.

Food, Nutrition, and Rural Development

-- Give increased attention to projects that will help elucidate and take advantage of the linkages between these program areas and fertility, particularly focusing on the very poor.

-- Give emphasis to especially those programs that help

reduce unequal distribution of income and other goods and services.

-- For rural development as a whole give emphasis to a "package" of policies and supporting programs and projects designed both to foster production and slow fertility growth as consistent with LDC objectives and preferences and within the limitations of management capacity, which has often proved a particularly serious problem in "package" programs.

-- Give increased attention to projects which encourage community-based organizations and local managerial capability.

-- Take account of potential fertility effects of any proposed redistribution of the land.

-- Test the use of community or personal incentives (relevant for either AID or PL 480; major additional study should be devoted to this area).

-- Design ways to encourage profitable employment for women in non-traditional, non-menial occupations.

-- Give increased attention to planning, administering, and evaluating programs outlined in this section.

Particularly on Nutrition:

-- Encourage integration with health and family planning services where appropriate.

-- Encourage programs having direct impact on reduced fertility, such as promotion of breastfeeding.

Education

-- Give major attention to increasing the number of female beneficiaries in all programs (especially where males outnumber females significantly).

-- Give major attention to expanding, opportunities for basic education for girls.

-- Encourage incorporation of messages on the benefits and methods of family planning into formal and non-formal education programs of all types -- in schools, through rural extension work, through clubs, etc.

Health

-- Encourage development of low cost integrated health, nutrition and family planning services for the majority where integration makes sense (either in one organizational system to assure efficient coordination of all programs -- organizationally integrated or free-standing -- that may substantially affect health and fertility).

-- Give major attention to maternal and child health with attention to child-spacing and lactation as critical health measures.

Funding Levels

In the area of development policies and programs affecting fertility it is even more difficult to discuss funding levels, except to say that increased attention should go to programs which, while serving their primary purposes, are likely to have a secondary impact on fertility. It should be pointed out specifically that non-Title X population funds may and indeed should be used in addition to population funds to explore links between fertility and other aspects of development, to help plan multi-faceted programs affecting fertility, and to help implement and evaluate such programs.

SUMMARY: AN INTEGRATED APPROACH

Basically this analysis suggests the fastest way to improve individual levels of well-being among the poor may be a package or integrated approach[1/] -- combining the most effective, safe, affordable and accessible family planning services and information with development policies and programs tailored to affect fertility as well as to fulfill their primary purposes. This will enable us to influence fertility -- always in keeping with the LDC's own objectives and preferences -- through our Title X assistance and through other budgets that may impact on fertility too. This course seems most likely to achieve the rapid and massive reductions in birth rates needed to reach birth rate targets of the LDCs and eventual population stability. This strategy is in full harmony with key recommendations of the World Population Plan of Action adopted unanimously in Bucharest in 1974. Specifically, it responds to paragraphs 31 and 32 of the Plan:

1/ It must always be kept in mind that "packaging" is instrumental and that, therefore, (a) no one package is optimum for universal application, and (b) the acceptance of any package in a particular setting requires the participation, in designing and developing the package, of those who lead and influence the potential acceptors.

"31. It is recommended that countries wishing to affect fertility levels give priority to implementing development programs and educational and health strategies which, while contributing to economic growth and higher standards of living, have a decisive impact upon demographic trends, including fertility. International co-operation is called for to give priority to assisting such national efforts in order that these programmes and strategies be carried into effect.

32. While recognizing the diversity of social, cultural, political and economic conditions among countries and regions, it is nevertheless agreed that the following development goals generally have an effect on the socio-economic content of reproductive decisions that tends to moderate fertility levels:

(a) The reduction of infant and child mortality, particularly by means of improved nutrition, sanitation, maternal and child health care, and maternal education:

(b) The full integration of women into the development process, particularly by means of their greater participation in educational, social, economic and political opportunities and especially by means of the removal of obstacles to their employment in the non-agricultural sector wherever possible. In this context, national laws and policies, as well as relevant international recommendations, should be reviewed in order to eliminate discrimination in, and remove obstacles to, the education, training employment and career advancement opportunities for women;

(c) The promotion of social justice, social mobility, and social development particularly by means of a wide participation of the population in development and a more equitable distribution of income, land, social services and amenities;

(d) The promotion of wide educational opportunities for the young of both sexes, and the extension of public forms of pre-school education for the rising generation;

(e) The elimination of child labour and child abuse and the establishment of social security and old age benefits;

(f) The establishment of an appropriate lower limit (i.e. minimum age) for age at marriage."1/

1/ This could be used to raise the minimum age for legal marriage, thus postponing.

Country Priorities

We have assessed experience with fertility-reducing programs and policies in a variety of countries where AID has had significant programs, and have drawn conclusions on program directions accordingly. Obviously the same type of program will not do for all countries; thus, our general policy and program strategy must be adjusted considerably for a given country, and an approach developed that makes sense in that country. The overall shape of all AID programs actually operating will depend on what countries we actually assist. Country allocation decisions naturally reflect both U.S. economic or political interests and prospects for meeting program objectives -- in this case, reducing world fertility.1/ Here we propose to give only rough guidelines as to the countries in which AID may concentrate its population-related assistance. Special concern exists for thirteen countries, excluding China, which contribute most to current world population growth: Bangladesh, Brazil, Colombia, Ethiopia, Egypt, India, Indonesia, Mexico, Nigeria, Pakistan, Philippines, Thailand and Turkey. But AID does not operate major bilateral population programs in about half of those countries at present; nor can we mount massive

1/ It bears emphasizing that reducing fertility is only one of AID's objectives under the mandate -- and that it is viewed as a means of facilitating per capita improvements in well-being.

programs through intermediaries of the scope, design, and vigor we would want. Thus the Agency is also determined to pursue opportunities in a limited number of other countries interested in reducing fertility where prospects seem bright or where unusually good opportunities exist for developing prototypes of programs that may also prove helpful in less accessible or otherwise neglected countries. We are continuing our analysis of program prospects, requirements, problems, etc. in order to refine our list of country recipients, assuring adequate program focus, and expect to make considerable further progress in this area in the next several months.

TREASURY STATEMENT OF CLARIFICATION TO THE PRESIDENT

The Department of Treasury supports the general population strategy put forward in the First Annual Report on U.S. International Population Policy. In particular, we favor increasing U.S. funding for population assistance provided that there are adequate program controls to assure efficient allocation of the additional resources.

Treasury believes that the report in its present form does not deal adequately with a number of significant issues which bear directly on the question of controls. These issues were defined in NSDM 314, wherein you directed that the Under Secretaries Committee evaluate:

(1) The effectiveness of population control programs in countries at all levels of development;

(2) The program efforts of AID and other national and international groups; and

(3) Provide detailed analysis of the funding levels recommended in the NSSM 200 study, including the development of performance criteria.

Treasury's concern is that, in the years ahead, we could easily lose sight of the necessity to establish stronger program controls in a rush to increase the volume of U.S. population assistance. Unless there is inter-agency agreement on appropriate controls in advance of any major programs expansion, Treasury seriously doubts that the U.S. will derive maximum benefit from any additional resources in terms of achieving meaningful reductions in population growth rates abroad.

Therefore, Treasury is unable to give its unreserved endorsement to the attached report until such time as we become convinced that the Task Force intends to deal comprehensively with all the issues you singled out for special attention in NSDM 314. Treasury also believes that the Under Secretaries Committee must assume a more important role in establishing overall population funding levels. The appropriate levels would be based on an analysis of the key-country program requests annually submitted by the country missions. This, we believe, is the role you envisaged that the Under Secretaries Committee should play when you asked that it "examine specific recommendations for funding in the population assistance and family planning field for the period after FY 1976" (NSDM 314).

PROPOSED PRESIDENTIAL STATEMENT

Today, August 19, marks the second anniversary of the opening of the United Nations World Population Conference at Bucharest, Romania.

This Conference, attended by high-level representatives of 138 countries of the world, adopted a World Population Plan of Action which proclaimed the principle that "all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children and their responsibilities towards the community." Further, the Plan of Action recommends that "all countries encourage appropriate education concerning responsible parenthood and make available to persons who so desire advice and means of achieving it."

The Bucharest Conference represented a major advance in achieving worldwide support for family planning, in specifying measures to give equal status to women, and in recognizing that population policies and programs are

integral parts of economic and social development.

Over the past two years, there has been some encouraging progress in the implementation of the Plan of Action. Today, most people of the world live in countries whose governments have adopted population policies and programs of their own creation, responsive to their own national needs. A number of developing countries which initiated such programs 5 to 10 years ago, have already been successful in reducing their birth rates, thus demonstrating that population growth can be moderated as proposed by the Plan of Action. Even in countries whose governments have not taken a stand on this issue, there are growing numbers of people and organizations that recognize the importance of child spacing in terms of the health of mother and child.

For its part, the United States will continue to join other donors in providing all feasible assistance to developing countries which request and make good use of aid in reducing rapid population growth. We will continue to give full support to international organizations like the United Nations Fund for Population Activities and to private voluntary organizations, in marshalling resources and talent for coping with

population issues in countries requesting assistance.

U.S. policy will comply with those suggestions in the World Population Plan of Action which urge that population program assistance granted to developing countries with high population growth rates be integrated into the overall development process so as to assure that the on-going development programs will also have a moderating influence on population growth.

Acting on its offer at Bucharest, the United States pledged support at the Seventh Special Session of the UN General Assembly last September for a major expansion of the efforts already under way, including those of the World Health Organization, to help developing countries establish low-cost integrated delivery of basic health services at the community level. These services will combine medical treatment, family planning, and nutritional information, using locally trained paramedical personnel.

All these and related measures are set forth in U.S. policy on international population which I approved last November and which is being carried out with the assistance and advice of a newly established Interagency Task Force on Population Policy that includes representatives of all U.S. Government Agencies concerned.

Clearly, there is a need for an expanded worldwide effort to cope with the problem. Excessive population growth is responsible in many parts of the world for rising dependence on imported food, for growing unemployment and underemployment, for serious environmental deterioration, and for a surge of humanity into already overcrowded cities lacking in housing, sanitation, and other basic facilities. All this creates serious social and political problems, as well as dashing the hopes of countless millions of people for economic development and progress.

Population policies are not an end in themselves but they are directly related to mankind's aspirations: to improve conditions of life for ourselves, our children, and for countless generations to come, as well as to promote security and lasting peace among nations.